**Wakefield Advocacy Together Hub**   
Referral Form

Please complete this form and return by **email** to:

**Tel: 01924 361050**

Email:**Wakefieldadvocacy@together-uk.org**

**ALL BOXES MUST BE COMPLETED**

**All Referrals MUST allow TWO WEEK NOTICE prior to any meetings the Advocate is to attend.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name of the person being referred**  (also give familiar name if different) | | | |  |  |  |
| **Current Location**  (also give previous location if applicable) | | |  |  | | |
| **Tel number:** | |  |  |  | | |
| **Date of birth:** | |  |  |  | | |
| **Date of referral:** | |  |  |  | | |
|  |  |  |  |  |  |  |
| **Name of Referrer:** | | |  |  | | |
| **Job Title & Team:** | |  |  |  | | |
| **Tel number & Email :** | |  |  |  | | |
| **Address :** | |  |  |  | | |
|  | |  |  |  | | |
| **Name of ‘Decision Maker’ (if different from referrer)** | | |  |  | | |
| **Job title:** | | |  |  | | |
| **Tel number & Email:** | |  |  |  | | |
| **Address:** | |  |  |  | | |
|  | |  |  |

**DECISION TYPE** (please tick ONE only)

|  |  |  |  |
| --- | --- | --- | --- |
| **Under Care Act**  Safeguarding Vulnerable Adult  Care & Support – including Psych or Acute Hosp discharge  Care Review  Care Assessment  Carers Assessment  Child In Transition | **Under Mental Cap Act**  Change of Accommodation  Serious Medical Treatment | **Under the Mental Health Act**  Section 2  Section 3  CTO / Guardianship  Conditionally discharged restricted patient  Section 57  ECT | **1.2 Rep**  Referral From Legal team |

**Please note - For IMCA Referrals**

Please confirm a Decision- Specific Capacity Assessment has been completed: **YES/NO**

Date Of Capacity assessment \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Completed by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*The IMCA may request a copy of the assessment. Please provide a copy or be able to access this if requested

**Please note – For Care Act Referrals**

Does the person referred have substantial difficulty (As Described in the Care Act? **YES x**

Are there any appropriate family or friends available to be consulted on the decision? **YES/NO**

If there is family however, they are not appropriate, please explain why they are not:

*\*Please note paragraph 10.79 of the MCA Code of Practice states that people simply disagreeing with decision makers does not make them inappropriate to be consulted. If the family will be present at the best interest then an* ***IMCA CANNOT*** *be involved)*

**Please describe the decision that the Advocacy Service is being consulted on:**

Are there any potential **RISK** to the advocate in a one-to-one meeting? **YES/NO**

If **YES** please provide details:

Are there any specific needs the person has such as communication/access issues? **YES**

If **YES** please provide details:

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Are there any Meetings Already booked regarding this case? **YES/NO**

If there are meetings booked, please provide the date

**Persons ethnicity;** En/Wel/Sc/N.Ir/Br : Irish Other white: Caribbean: African Wte Asian Other mixed multi ethnic: Indian Pakistani Bangladeshi Chinese Other Asian Other:

**Persons difficulty:** (please tick)

Mental Health Brain injury ASD Learning Disability Cognitive Impairment Dementia

Sensory Impairment Substance Misuse Unconscious Carer Older Person Phys Disability

Other:

Once Complete Please Return by Email to: Wakefieldadvocacy@together-uk.

Any issues which arise while completing this form please call the Advocacy office on: 01924 361050