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| **asist main logo 2010Community DoLS Advocacy Referral Form ©** |  |

Service available Monday to Friday 9am to 5pm (excluding bank holidays)

**(Referrals only accepted from Staffordshire and Stoke City Council Adult Social Care Team)**

**Eligibility Checklist**

**YES**

approved and signed by the **Decision Maker** (a health care professional or a social care practitioner)

Not eligible

16+ years, **and**

Assessed as lacking capacity **and**

Not free to leave their place of care **and**

The person requires continuous supervision and control (in best interest)

**YES**

**NO**

**NO**

**An Advocate will:**

Please complete the attached referral form.

For further information please contact the Asist office.

Visit the person regularly to ask their views and wishes and see that they are being cared for well.

Check that the treatment and care provided is the least restrictive of their basic rights and freedom.

Help the person to understand their authorisation and how it affects them and support them to exercise their rights if they want to do that.

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| **To discuss a referral please contact Asist on 01782 845584** |

**Fill in this form and send to Asist by emailing** [referrals@asist.co.uk](mailto:referrals@asist.co.uk)

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| **asist main logo 2010Community DoLS Advocacy Referral Form** | | | | | | | | | | | | | | | | | | | |  |
| **Service available Monday to Friday 8.30am to 5pm (excluding bank holidays)**  **(Referrals only accepted from Staffordshire and Stoke City Council Adult Social Care Team)** | | | | | | | | | | | | | | | | | | | |  |
| **About the person requiring support** | | | | | | | | | | | | | | | | | | | |
| **Mr/ Mrs:** | | **Name:** | | | | | | | | | | | | | **Date of birth:** | | | | |
| **Gender:** | | **Preferred Pronouns:** | | | | | | | | | | | | | **Mobile:** | | | | |
| **Current Address:** | | | | | | | | | | | | | | | **Tel:** | | | | |
| **Postcode:** | | | | |
| Sexual Orientation: | | | | | | | | | | | | | | | **Email:** | | | | |
| Religion; please include any cultural or religious needs) | | | | | | | | | | | | | | |
| **Own Home:** | | | **Care Home:** | | | | | | | **Hospital:** | | | | | **Other:** | | | | |
| **Social References:** (P numbers, LAS, etc) | | | | | | | | | | | | | | | | | | | |
| **How does this person communicate?** | | | | | | | | | | | | | | | | | | | |
| **Preferred Language:** | | | | | | | | | | **Dialect:** | | | | | | | | | |
| **Spoken Language** | | | | |  | | | | | **Gestures/Facial Expressions/Vocalisations** | | | | | | |  | | |
| **British Sign Language** | | | | |  | | | | | **Words/ Pictures/ Makaton** | | | | | | |  | | |
| **Not known** | | | | |  | | | | | **Other, please give details:** | | | | | | | | | |
| **Known Risks (to themselves or others):** | | | | | | | | | | | | | | | | | | | |
| **What is the person’s additional support needs?** | | | | | | | | | | | | | | | | | | | |
| **Mental Health problems** | | | | | |  | | | | **Physical Health** | | | | | | |  | | |
| **Cognitive Impairment** | | | | | |  | | | | **Autism Spectrum Condition** | | | | | | |  | | |
| **Learning Disability** | | | | | |  | | | | **Serious Physical Illness** | | | | | | |  | | |
| **Other** | | | | | |  | | | | **Please specify:** | | | | | | | | | |
| **Who is the referral for?** | | | | | | | | | | | | | | | | | | | |
| **An adult with care and support needs** | | |  | **A carer with support needs** | | | | | | | |  | | **A parent of a child open to Children’s Social Care** | | | | |  |
|  | | | | | | | | | | | | | | | | | | | |
| **Type of process** | | | | | | | | | | | | | | | | | | | |
| **Witness Statement** | | | | | | | | | | | **On-Going representation by CoP** | | | | | | | | |
| **Ethnicity** | | | | | | | | | | | | | | | | | | | |
| **White** | **Asian or Asian British** | | | | | | **Mixed** | | | | | | **Black or Black Irish** | | | **Chinese or not established** | | | |
| British  Irish  Other | Pakistani  Bangladeshi  Indian | | | | | | White & Black Caribbean  White & Black African  White & Asian | | | | | | Black Caribbean  Black African | | | Chinese  Ethnicity not established | | | |
| **Other, please specify:** | | | | | | | | | | | | | | | | | | | |
| **When making Referrals please provide proposed Care Plans and Assessments relating to the deprivation** | | | | | | | | | | | | | | | | | | | |
| **Please list attached documents for this referral or provide quotations here.** | | | | | | | | | | | | | | | | | | | |
| **Nature of Substantial Difficulty (please tick all that apply)** | | | | | | | | | | | | | | | | | | | |
| **Understanding relevant information** | | | | | | | |  | **Retaining information** | | | | | | | | |  | |
| **Using or weighing up information** | | | | | | | |  | **Communicating their views, wishes and feelings** | | | | | | | | |  | |
| **asist main logo 2010Please confirm that there is no one appropriate OR available to facilitate the persons active involvement.** | | | | | | | | | | | | | | | | | | | |
| **I confirm that there is no one appropriate or available to facilitate involvement:** | | | | | | | | | | | | | | | | | | | |
| **Additional Information** | | | | | | | | | | | | | | | | | | | |
| **Brief summary of situation and reason for requesting an Advocate.**  Please provide any additional background information which will help the Advocate to support the person being referred.  What steps need to be taken to maximise the person’s full participation (For example, consideration of mental capacity, sensory needs, autism related needs and confidence.  This could also include interpreters, appropriate adult, family members, information and advice, communication aid, appropriate time of day/effects of medication, suitable environment). | | | | | | | | | | | | | | | | | | | |
| **Please give details of any forthcoming meeting dates.**  Please provide dates/location/ time/ in person or via Teams. Are other professionals in attendance? What is the meeting for? | | | | | | | | | | | | | | | | | | | |
| **Referrer Contact Details** | | | | | | | | | | | | | | | | | | | |
| **Name of referrer:** | | | | | | | | | | **Job Title:** | | | | | | | | | |
| **Team:** | | | | | | | | | | **Organisation:** | | | | | | | | | |
| **Email:** | | | | | | | | | | **Tel** | | | | | | | | | |
| **Date of Referral:** | | | | | | | | | | **How did you hear about us:** | | | | | | | | | |

**To be completed by Children and Young Peoples Services only**

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| **Adult Social Care (ASC) Assessor Details** | | |
| **Are or will ASC be involved?** | | |
| **Name of ASC Social Worker/ Assessor:** | | |
| **Team (if known):** | | |
| **Telephone Number:** | **Email address:** | |
| **Consent** | | |
| **Have you discussed this referral with the person being referred? (where appropriate)** | |  |
| **Has the person agreed to this referral being made?** | |  |
| black phone**To discuss a referral please contact Asist on 01782 845584** | | |

**Fill in this form and send to Asist by emailing** [referrals@asist.co.uk](mailto:referrals@asist.co.uk)

**Head Office: Asist, Winton House, Stoke Road, Stoke-on-Trent, ST4 2RW**

