**Spot Purchase Advocacy Referral Form**

For Asist to be able to provide paid advocacy support for those living within

Staffordshire and Stoke-on-Trent who do not qualify for free advocacy provision.

Referrals accepted from health and social care teams.

**ABOUT THE PERSON YOU ARE REFERRING:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Full Name** |  | | | |
| **Date of Birth** |  | | | |
| **Permanent Address** |  | | | |
| **Postcode** |  | | | |
| **Current Address (if different)** |  | | | |
| **Postcode** |  | | | |
| **Is the person’s current address** | | | | |
| Own home | |  | Residential/ nursing setting |  |
| Supported living | |  | Hospital |  |
| Other: | | | |  |
| **Phone number(s)** |  | | | |
| **Email address** |  | | | |
| **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 advocacy process?** (Tick one) | DoLS/RPR  CHC Assessment  Care Act  Health Issues  Parental  BAME  Children and Young people’s advocacy | | | |
| **What process does the person require support with?** (Tick one) | Assessment  Care and Support planning  Review  Safeguarding Enquiry  Safeguarding Adult Review  Complaints  Child in Need  Child Protection  PLO/Care proceedings  Health issues  DoLS/RPR  Cultural issues  Legal issues  Activities  Looked after Children reviews/meetings  Other (please specify): | | | |
| **Disability or impairment** | Learning disability  Mental health condition  Cognitive impairment  Physical health  Autistic spectrum disorder  Serious physical illness | | | |
| **Gender** | Female  Male  Female, Male at birth  Male, Female at birth  Non-binary  Prefer not to say  Not listed, **please specify**: | | | |
| **Pronouns** | She/her  He/him  They/them | | | |
| **Sexual orientation** | Heterosexual  Bisexual  Lesbian or gay  Prefer not to say  Not listed, **please specify:** | | | |
| **How does the person communicate?** | English  Other spoken language, **please specify:**  British Sign Language  Words/pictures/Makaton  Gestures/expressions/vocalisations  No obvious means of communication  Not listed, **please specify:** | | | |
| **Ethnic origin** | Arab / British Arab  Asian / British Asian  Black / Black British  Gypsy / Roma / Traveller  Mixed heritage  White British – English, Welsh, Scottish, N. Irish  White Irish  White other  Prefer not to say  Not listed, **please specify:** | | | |
| **Religion or belief** | Atheist (no religion)  Christian (all denominations)  Buddhist  Sikh  Hindu  Jewish  Humanist  Pagan  Muslim  Not listed, **please specify:**  Person’s own description: | | | |
| **Does the person identify as having a disability or long-term health condition?** | | | | |
| Yes  No Please specify: | | | | |

**ABOUT YOU:**

|  |  |
| --- | --- |
| **Referrer Details** | |
| Name |  |
| Role |  |
| Team |  |
| Place of work (including address) |  |
| Phone number |  |
| Email address |  |

|  |  |
| --- | --- |
| **Adult Social Care Assessor Details** | |
| Are, or will ASC be involved? |  |
| Name of ASC Social Worker/Assessor |  |
| Team |  |
| Place of work (including address) |  |
| Phone number |  |
| Email address |  |

|  |  |
| --- | --- |
| **Manager’s authorisation:** | |
| Team Managers Name |  |
| Organisation/ Team |  |
| Place of work (including address) |  |
| Phone number |  |
| Email address |  |
| Team Manager sign (electronic) |  |
| Date |  |

**REFERRAL INFORMATION:**

|  |
| --- |
| **Summary of situation and reason for requesting an advocate** |
| Please provide details: |

|  |
| --- |
| **Further relevant information** |
| Please provide details: |

|  |  |  |
| --- | --- | --- |
| **Substantial difficulty** | Yes | No |
| Please provide detail: | | |

|  |  |  |
| --- | --- | --- |
| **Capacity** | | |
| Has the person been formally assessed to lack mental capacity? | Yes | No |
| Date of the capacity assessment: | | |
| Who completed the capacity assessment: | | |
| What specific decision was the capacity assessment regarding? | | |
| Please confirm there are no known consultable family or friends: | Yes | No |

|  |
| --- |
| **Family and friend involvement** |
| Does the person have an appropriate adult willing and able to facilitate their involvement in the process/ processes and does the individual consent to their involvement?  If not, please provide further detail:  Please provide details about any safeguarding concerns or protective measures: |

|  |
| --- |
| **Significant dates** |
| Please provide details for any impending meetings or deadlines: |

|  |
| --- |
| **Risks** |
| Are there any risks pertaining to the person (or their family/friends)? Are there any risks relating to an advocate visiting the person where they live? |
|  |

|  |  |  |
| --- | --- | --- |
| **Consent** | | |
| Due to GDPR (2018), we need authorisation to say that people agree to Asist holding their personal information included on this form.  If the person being referred is deemed to lack capacity, the referrer must indicate they are referring in the person’s best interest. | | |
| **Does the person have capacity to consent to this referral?** | Yes | No |
| **If yes, has consent been obtained?** | Yes | No |
| **Is the referral being made in best interest?** | Yes | No |

|  |
| --- |
| **Disclaimer** |
| **Please** note where possible, provide us with 2 weeks’ notice for any meetings to allow the advocate adequate time to support the person being referred.  **Please** note that no advocacy work will be started until the return of a signed authorisation form and purchase order. |
| **Please** make sure information on this form is correct before submitting. |

**Please email completed form to: referrals@asist.co.uk**