**Statutory Independent Care Act Advocacy (ICAA) REFERRAL**

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| **Advocacy and the duty to involve**  Local authorities must involve people in decisions made about them and their care and support. No matter how complex a person’s needs, local authorities are required to help people express their wishes and feelings, support them in weighing up their options, and assist them in making their own decisions.  **When does the advocacy duty apply?**  The advocacy duty will apply from the point of first contact with the local authority, and at any subsequent stage of the assessment, planning, care review, safeguarding enquiry, or safeguarding review. If it appears to the authority that a person or carer has care support needs, then a judgement must be made as to whether that person has **substantial difficulty** in being involved. If they do, and there is not an **appropriate individual** to support them, an **independent advocate** must be appointed to support and represent the person for the purpose of assisting their full involvement. |

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| Date of referral |  | | | | | | | |
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| **Referrer’s details** | | | | | | | | |
| Is this a self-referral? | | YES | |  | NO | |  | If YES, go to Service Group |
| First name |  | | | | | Surname | |  |
| Organisation |  | | | | | Job Title | |  |
| Telephone |  | | | | | Mobile | |  |
| Email |  | | | | | | | |

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| **Client information** | |
| Full name (including title) |  |
| Date of birth |  |
| Home address |  |
| Post Code |  |
| Address of current location (if different from home address) |  |
| Post Code |  |
| Telephone number |  |
| Mobile number |  |
| Email |  |

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| **Service Group** (check one box only) | | | |
| Adult 18-65 in the community |  | Adult 18-65 in hospital |  |
| Older person 65+ in the community |  | Older person 65+ in hospital |  |
| Carer |  | Vulnerable person |  |
| Other (please specify) |  | | |

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| **Client current location details** | | | |
| Own home |  | Own home with support |  |
| Supported living |  | Acute psychiatric unit |  |
| Dementia ward |  | Care/Nursing home |  |
| Prison |  | Forensic secure unit |  |
| Homeless |  | No fixed abode |  |
| Hospital |  | Other institution |  |

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| **Preferred method of contact** | | | |
| Telephone |  | Mobile |  |
| Text |  | Email |  |
| Post |  | Any |  |
| Cannot be contacted directly |  |

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| **Client’s primary communication method** | | | |
| Spoken English |  | British Sign Language (BSL) |  |
| Other spoken language (please specify and also whether English is spoken) |  |  | |
| Words/Pictures/Makaton |  | Gestures/Facial expressions/Vocalisations |  |
| Other (please specify) |  |  | |
| No obvious means of communication |  | Not known |  |

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| **Does the client have a military connection?** | | | |
| Yes, serving |  | Yes, Veteran |  |
| Yes, carer relationship |  | No |  |
| Not known |  | Prefers not to say |  |

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| **Does the client consider themselves to have a disability?** | | | |
| Yes |  | No |  |
| Don’t know |  | Prefers not to say |  |

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| **Is there a MAIN disability/impairment considered particularly relevant to this case? (check ONE box only)** | | | |
| Mental health problem |  | Physical disability |  |
| Acquired brain injury |  | Serious physical illness |  |
| Sensory (hearing) |  | Sensory (sight) |  |
| Learning disability |  | Dementia/Alzheimer’s |  |
| Asperger’s/Autism Spectrum Condition |  | Cognitive impairment |  |
| Unconsciousness |  | Other (please specify below) |  |

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| **What type(s) of disability or impairment does the client have? (select all that apply)** | | | |
| Mental health problem |  | Physical disability |  |
| Acquired brain injury |  | Serious physical illness |  |
| Sensory (hearing) |  | Sensory (sight) |  |
| Learning disability |  | Dementia/Alzheimer’s |  |
| Asperger’s/Autism Spectrum Condition |  | Cognitive impairment |  |
| Unconsciousness |  | Other (please specify below) |  |
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| **ICAA referral details** | | | |
| **Local authority of referrer** | | | |
| Southend-on-Sea |  | Other (please specify below) |  | |
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| **Referral category** | | | |
| OPPD |  | MH |  | |
| LD |  | Other |  | |

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| Where appropriate, has the client been made aware of the referral? | YES |  | NO |  |
| Where appropriate, has the client given their consent to the referral? | YES |  | NO |  |
| Are you satisfied the referral meets the criteria under the Care Act? (and is in the best interests of the client if they have not been made aware, or given their consent) | YES |  | NO |  |

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| **Referral reason (check ONE box only)** | | |
| An adult needs assessment | |  |
| A carer’s assessment | |  |
| The preparation of a care and support plan, or support plan | |  |
| The review of a care and support plan | |  |
| The review of a carer’s support plan | |  |
| A child’s needs assessment under Transition to adult care/support | |  |
| A child’s carer’s assessment under Transition to adult care/support | |  |
| A young carer’s assessment | |  |
| A safeguarding enquiry | |  |
| A safeguarding adults review | |  |

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| **Does the person have Substantial Difficulty in:** | | |
| Understanding relevant information? | |  |
| Retaining information? | |  |
| Using, or weighing up information? | |  |
| Communicating views, wishes and feelings? | |  |

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| **Is the client subject to Mental Health Act section 117 Aftercare?** | | | | | | | |
| YES |  | NO |  | Don’t know |  |

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| **Previous IMCA Involvement?** | | | | | | | |
| YES |  | NO |  | Don’t know |  |

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| **Why does the person need an Independent Advocate?** | | |
| Only paid professional help available | |  |
| No friend/family member available | |  |
| No preferred friend/family member available to them | |  |
| No friend/family member available without a vested interest | |  |
| Conflict/dispute with the Local Authority | |  |
| Other (please provide details below) | |  |
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| **Names and contact details of others involved that need to be consulted** | | | |
| 1 |  | 2 |  |
| 3 |  | 4 |  |

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| **Please detail any risks or behaviours the advocate needs to be aware of when dealing with the referral. If you are not aware of any risks, please write “No known risks”** |
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| **Describe the current circumstances of the client and explain what support is needed from the advocate. Please provide dates of any meetings already planned** |
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| **Are you aware of any records of the person’s wishes?** | | | |
| YES (please provide details below) |  | NO |  |
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| Emergency contact name |  |
| Emergency contact relationship |  |
| Emergency telephone number |  |

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| **Declaration** |
| * I declare that I wish to instruct an ICAA * I am providing this information and making this referral in relation to the Care Act 2014 * In accordance with current Data Protection legislation, I agree to Southend Advocacy Hub partners holding personal information (including information on this form) * I understand the provision of an advocacy service is subject to the patient meeting eligibility criteria |
| **Signature of referrer** |
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| **Monitoring Information** | | | | | | | | | |
| **Ethnicity** | | | | | | | | | |
| **Asian** |  | **Black** |  | **Mixed** |  | **White** |  |  |  |
| British |  | British |  | British |  | British |  | Other |  |
| Bangladeshi |  | African |  | Asian/White |  | Irish |  | Declined |  |
| Chinese |  | Caribbean |  | Black African/White |  | Other |  | Unknown |  |
| Indian |  | Other |  | Black Caribbean/White |  |  |  |  |  |
| Pakistani |  |  |  | Other |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |

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| **Gender** |  | | **Sexual Orientation** |  | **Religion** |  |
| Female | |  | Bisexual |  | Buddhist |  |
| Male | |  | Gay Male |  | Christian |  |
| Intersex | |  | Heterosexual |  | Hindu |  |
| Transgender | |  | Lesbian |  | Jewish |  |
|  | |  | Declined |  | Muslim |  |
|  | |  | Not known |  | Sikh |  |
|  | |  |  |  | Other |  |
|  | |  |  |  | No religion |  |
|  | |  |  |  | Declined |  |
|  | |  |  |  | Not known |  |

Please email the completed form to: [advocacy@southessexadvocacy.org](mailto:advocacy@southessexadvocacy.org)

Or post to: Southend Advocacy Hub

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