|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please note all fields must be completed or the form will be returned: This could delay an Advocate being allocated. Where Not Applicable please indicate by inserting N/A** | | | | | | | | |
| **Date of Referral:** | | | | | | | | |
| **Client Details** | | | | | | | | |
| Client Name | |  | | Client DOB | | |  | |
| Home Address | |  | | | | | | |
| **Address at point of referral** (if different from above). If hospital, please include ward name/number | |  | | | | | | |
| Post code | |  | | | Local Authority/Borough | |  | |
| Telephone | |  | | | Email | |  | |
| GP Surgery the client is registered with | |  | | | GP Surgery contact number | |  | |
| **Type of advocacy required (please tick only one box per referral)** | | | | | | | | |
| Independent Mental Health Advocacy (IMHA) | | | | | | |  | |
| NHS complaints Advocacy (IHCA) | | | | | | |  | |
| Generic or community advocacy | | | | | | |  | |
| **If IMHA please tick referral reason (please only tick one box per referral)** | | Detained under Mental Health Act  **Please add section and section start date** | | | | |  | |
| Conditional Discharge | | | | |  | |
| Subject to Guardianship | | | | |  | |
| Community Treatment Order | | | | |  | |
| Considered for treatment to which Section 57 applies | | | | |  | |
| Details **(please provide as much additional information as you can about the referral)** | | | | | | | | |
|  | | | | | | | | |
| Please provide consent below | | | | | | | | |
| Do you consent to your information being added to our case management system | | | | | | | | Yes/No |
| If **not** please give details: | | | | | | | | |
| Please detail any risk issues the advocacy services need to be aware of below, or confirm there are no known risks | | | | | | | | |
|  | | | | | | | | |
| **Name and details of person completing this referral form** | | | | | | | | |
| **Name** |  | | **Job Title** | | |  | | |
| **Telephone No** |  | | **Email** | | |  | | |
| **Relationship to client** |  | | **Date** | | |  | | |
|  | | | | | | | | |
| **Additional information – Please tick those that apply.   This is optional; however, it does help us to better understand who we are supporting.** | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- |
| **Religion or spiritual belief** | | | | | | |
| Buddhist |  | Jewish | |  | Other Religion |  |
| Christian |  | Muslim | |  | No Religious Belief |  |
| Hindu |  | Sikh | |  | Do not wish to answer |  |
| **Ethnicity** | | | | | | |
| Asian or Asian British - Any Other Asian Background |  | Mixed - Any other mixed background | |  | White - Any Other White Background |  |
| Asian or Asian British - Bangladeshi |  | Mixed - White and Asian | |  | White - British |  |
| Asian or Asian British - Indian |  | Mixed - White and Black African | |  | White - Gypsy or Irish Traveller |  |
| Asian or Asian British - Pakistani |  | Mixed - White and Black Caribbean | |  | White - Irish |  |
| Black or Black British - African |  | Do not wish to answer | |  | Not provided |  |
| Black or Black British - Caribbean |  | Other Ethnic Group - Any other ethnic group | |  | Do not wish to answer |  |
| Black or Black British - Other Black Background |  | Other Ethnic Group - Arab | |  |  | |
| **Sexual orientation** | | | | | | |
| Heterosexual / Straight |  | Bisexual | |  | Not Provided |  |
| Homosexual / Gay Man |  | Other | |  |  | |
| Lesbian / Gay Woman |  | Do not wish to answer | |  |  | |
| **Additional needs** | | | | | | |
| Learning Disability |  | Mental Illness | |  | Dementia |  |
| Autism |  | Acquired Brain Injury | |  | Other |  |
| **Communication needs / preferences** | | | | | | |
| Preferred language (please specify) |  | English language | |  | Other spoken language (please specify) |  |
| Preferred method of communication (please specify) |  | Able to read | |  | British Sign Language |  |
| Pictures / symbols |  | Makaton | |  | Gestures / facial expressions |  |
| Sounds / vocalisations |  | No formal means of communication | |  | Other support needs |  |
| Hearing impairment |  |  | | | | |
| **Additional information:** | | | | | | |
| Pregnant /maternity Yes/No | | |  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Gender |  | Identifies as same sex as at birth |  |
| Marital status |  | | |

|  |
| --- |
| Mental health diagnosis: |
| Details of any long-term physical health condition: |
| **Please return this referral form to:**  [**advocacyreferralhub@rethink.org**](mailto:advocacyreferralhub@rethink.org)  **Any queries please call 0300 7900 559 – Monday – Friday 9am till 5pm** |