Barking and Dagenham Advocacy Referral Form

Date of Referral		**Client ID Number** (Cambridge House use only)	
Client Details			
Client Name		Client DOB	
Home Address			
Address at point of referral (if different from above). If hospital please include ward name/number.			
Postcode		Borough	
Telephone		Email	

Type of Advocacy Required (please tick only one box per referral)	
Care Act Advocacy	
Independent Mental Capacity Advocacy (IMCA)	
Independent Mental Health Advocacy (IMHA)	

If IMCA please tick referral reason (Please only tick one box per referral)	Serious Medical Treatment	
	Change of Residence	
	28 Days in Hospital	
	Adult Protection	
	Care Review	
If IMHA please tick referral reason (Please only tick one box per referral)	Detained Under the Mental Health Act	
	Conditional Discharge	
	Subject to Guardianship	
	Community Treatment Order	
	Considered For Treatment To Which Section 57 Applies	
If Care Act please tick referral reason (Please only tick one box per referral)	Needs Assessment	
	Preparation of Care And Support Plan	
	Safeguarding	
	Review of Care and Support Plan	
	Complaint/Appeal	

Details (please provide as much additional information as you can about the referral. Use additional sheets as necessary)

Cambridge House

If client lacks capacity, please detail below who conducted the capacity assessment and where it can be located			
Name		Job Title	
Team		Department	
Borough		Address	
Telephone		Email	

Has a Capacity Assessment (as required by S.2 and S.3 of MCA 2005) been carried out?	Yes		No	
If yes, where can it be located?				

If client lacks capacity and a decision is being made in their best interest, please provide the details of the decision maker below	
Name of Decision Maker	
Job Title	
Team	
Department	
Telephone	
Email	
Borough	

Other People Involved (insert new rows as necessary)			
Contact details of other relevant people (professionals, family or friends)			
Name	Relationship to client	Telephone	Email

If Client has capacity, please complete below	
Is the Client is aware of referral (if no please explain in additional information above)	
Has the Client consented to the referral (if no please explain in additional information above)	

Client Need (please enter x in relevant box/es)	
Mental Health	
Learning Disability	
Dementia	
Acquired Brian Injury	
Serious physical Illness	
Cognitive Impairment	
Other …	

Mental Health Act Status (please enter x in relevant box)				
Is the client subject to the Mental Health Act?	Yes		No	
If yes, please indicate which section and why it is required				

Cambridge House

Ethnic Background (please enter x in relevant box)	M	F
White Irish		
White Other		
Mixed White & Black Caribbean		
Mixed White & Black African		
Mixed White & Asian		
Other mixed		
Asian or Asian British Indian		
Asian or Asian British Pakistani		
Asian or Asian British Bangladeshi		
Chinese		
Other Asian		
Black or Black British Caribbean		
Black or Black British African		
Other		
Withheld		

Primary Means of Communication (please enter x in relevant box)	
English	
Other spoken language Please specify…	
British Sign Language	
Words	
Pictures	
Makaton	
Gestures	
Facial Expressions	
Vocalisations	
No obvious means of Communication	
Comments	

Please detail any risk issues or incidents the Advocacy service should be aware of:	

Name and details of person completing this referral form			
Name		Email	
Telephone No		Relation to client	
Job Title		Date:	

Please Return This Referral Form to
chadvocacy@ch1889.org
Or post it to us
Advocacy at Cambridge House, 1 Addington Square, London SE5 0HF