CARE ACT REFERRAL

Confidential

Client Name:	
Date of Birth:	
Client ID:	
Home Address & Postcode:	
Funding Local Authority:	
Telephone Number:	
Email Address:	
Present location, postcode, tel. (if different from above) **If hospital please include ward number**	

Consent - Advocacy Operates under the GDPR Guidelines

Has client consented to this referral?	
If No Reason Why?	

Gender:		Ethnicity:	
Disability:			

Gender Identity:		Religion:			

Preferred method of contact:	Phone	Email	Post

Please detail any **risks** that the client may pose to our Staff that we should be aware of:

	Referrer Details	Other Professionals Involved
Name:		
Job/Role:		
Organisation/Team:		
Telephone:		
Email:		
Referral Date:		

ADVOCACY SERVICE INFORMATION

CARE ACT REFERRAL

☐ Assessment ☐ Review ☐ Safeguarding ☐ Support Planning

Will this person have a substantial difficulty in being involved in the process? ☐ Yes ☐ No

Has the client been deemed by the referrer as having no appropriate person to facilitate the clients engagement in the process? ☐ Yes ☐ No

REFERRAL REASON (Please add any relevant information inc. meeting dates)

Please return this form to -
Email: careact-**ref@stockportadvocacy.co.uk** Phone: **0161 480 8979**
Post: Stockport Advocacy, IMCA **48 Middle Hillgate, Stockport SK1 3DL**
www.stockportadvocacy.org.uk