**Age Cymru Gwent Advocacy Referral Form**

**Please complete and return to:** [acgadvocacy@agecymrugwent.org](mailto:acgadvocacy@agecymrugwent.org)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Referrer** |  | | | | **Contact Details** | |  |
| **Name**  **Preferred name** | |  | | | | Marital Status | |
| **DOB** | |  | National Insurance number ( If Known) | | |  | |
| **Address/postcode**  **Email address** | |  | | | | | |
| **Telephone** | | Home Mobile | | | | | |
| **Preferred contact method** | | Phone Mobile Text Letter Email Face to face | | | | | |
| **Alternative contact to arrange visit** | | Name | | Relationship | | Contact details | |
| **Gender** | |  | | Female | | Other | |
| **Ethnic Origin** | |  | | **Sexual Orientation** | |  | |
| **Religion / Cultural** | |  | | **Preferred /first Language** | |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Risks identified at time of assessment** | Yes ( Please specify) | No | Don’t Know |

|  |  |  |
| --- | --- | --- |
| **Service user in hospital** | Hospital | Ward/Contact Details |
| **Date of Admission** |  | |

|  |
| --- |
| **Advocacy issue** |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

|  |  |
| --- | --- |
| **Outcome client would like to achieve** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Capacity at time of referral** | Yes | No | Fluctuating | Not Known |
| **Additional details below if relevant** | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Mental Capacity – further details** | | | | | | |
| **Reason For Mental Capacity Assessment** |  | | | | | |
| **Has Formal Assessment Taken Place?** | NO Date  Assessed by: | | | | | No |
| **Areas and decisions that service user was assessed and reason for decision:** | | | | | | |
| **Outcome of Assessment** | | | | | | |
| **Does service user have Mental Capacity to make decision** | Yes | | No | | Fluctuating | |
| **Does service user have Lasting Power of Attorney or Appointee** | Yes – | | | | | No |
| **LPA/Appointee contact details:** | | | | | | |
| **Verification of Authority Sighted** | | Yes | | No | | |

|  |
| --- |
| **Additional Information** |
|  |
|  |
|  |
|  |
|  |
|  |