**Age Cymru Gwent Advocacy Referral Form**

**Please complete and return to:** acgadvocacy@agecymrugwent.org

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| **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** |  |

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

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

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| **Advocacy issue** |
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| **Outcome client would like to achieve** |  |

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

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|  **Mental Capacity – further details**  |
| **Reason For Mental Capacity Assessment** |  |
| **Has Formal Assessment Taken Place?** | NO DateAssessed 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 |

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|  **Additional Information**  |
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