Transitions Referral - Consent Form for referral to be made and information to be shared

Consent for Referral to be made

I am giving you permission for this referral to be made to Adult Social Care, Swindon Borough Council

How information about you will be shared.

I understand that you may need to share the information from my referral with professionals in other organisations, such as health services, housing services or voluntary organisations, to make sure that I can get the help I need.

Permission to Share My Information

I am giving you my permission to share the information in my referral for this purpose. I understand that I will be giving my personal information to you (Swindon Borough Council) and you will keep it safe on a management information system and use it to help me plan the support that I may need.

I understand that anonymised data will be used for research purposes to help improve future service provision for Adult Social Care.
Further information on how information is used (privacy notice), can be found on the following website:https://www.swindon.gov.uk/download/downloads/id/507/adult_social_care_services_privacy_notice.pdf

I understand that I can take away my permission at any time.

I am aware that if there is any particular organisation(s) or person that I do not want you to contact to request information or share my information with I can indicate this in the space below.

……..

To change or withdraw permission please contact the Learning Disability Duty Team on **01793 464819.**

I have read the above information and the Practitioner/ Social Worker has also advised me of how my information will be shared.			
Your Signature:		**Date:**	
Carer Signature:		**Date:**	
Other service user representative signature:		**Date:**	
The person has understood the form but is unable to sign for themselves.	☐		
Practitioner Signature:		**Date:**	

When the person lacks capacity to make decisions about the referral for him/herself. i.e. when the person experiences a condition that has been assessed as affecting their mental capacity to agree to a referral being made, or to the information in the referral being shared by professionals, or for the referral to be recorded on Adult Social Care management information systems, and there is someone who is appropriate to do this in the person's best interests, involving the person as much as possible (Mental Capacity Act 2005).

I am agreeing to the referral on behalf of this person in the capacity of (*please tick appropriate box*)**:**

Court of Protection Deputy for Finance:	☐	Health and / or welfare:	☐
Enduring Power of Attorney:	☐		
Lasting Power of Attorney for Finance:	☐	Health and / or welfare:	☐

(N.B The original documentation relating to the above roles must be seen and a copy taken for our records)

In the belief that I am acting in their best interests	☐
The information can be shared as stated above	☐

Your signature:	
Your relationship to the person:	
Date:	

Practitioner Signature:	
Practitioner name: (Print)	
Date:	