**Community DoLS/1.2 Rep Referral Form**

In making this referral, we assume you are preparing an application to the Court of Protection for a community DoLS because the person:

* is living somewhere other than a care home or hospital
* is not free to leave and is subject to complete or continuous supervision and control
* has been assessed as lacking capacity to consent to this
* does not have a friend or family member who can take on the role.

***The current care and support plan and draft COP11 (if available) should be attached to this referral.***

Depending on the geographical location of your client, you may be asked to complete a Spot Purchase

Agreement for payment of our work.

**If this is NOT the case, please call us on 0330 440 9000 and ask to speak to the local team.**

***If completing online, click once on relevant box to check. Write in text fields, where required.***

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| **Date of Referral:** | | | |
| **Professional Referrer’s Details** | | | |
| **Referrer First Name:** | | | **Last Name:** |
| **Organisation:** | | | |
| **Job Title or Relationship to Client:** | | | |
| Social Worker (Community)  Social Work Assistant  Team Manager Social Care  Care Manager  Administrator  Other | | | |
| **Address:** |  | | |
| **Postcode:** | | | |
| **Tel No:** | | **Mobile No:** | |
| **Email:** | | | |

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| **Main Disability** Is there a **main** disability or impairment considered particularly relevant to this case? | | |
| Check **ONE** box only | | |
| Mental Health Condition  Physical Disability  Sensory (Hearing)  Sensory (Sight) | Asperger’s /Autism Spectrum Condition  Cognitive Impairment  Acquired Brain Injury  Serious Physical Illness | Learning Disability  Dementia / Alzheimer’s  Unconsciousness  **NO** |

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| **Client Information** | | | |
| **Title:**  Mr  Mrs  Ms  Other | | **First Name:**  **Last Name:** | |
| **Date of Birth:** | | | |
| **E-mail** | | | |
| **Telephone No.** | | | **Mobile No.** |
| **Preferred method of contact:** | | | |
| Any  Telephone  E-mail  Post  Mobile Phone  Text  Cannot be contacted directly | | | |
| **What is the Client’s primary communication method?**  Not known | | | |
| Spoken English  Other Spoken Language (specify)  British Sign Language (BSL)  Other (specify)  Words/Pictures/Makaton  No obvious means of communication  Gestures/Facial Expressions/Vocalisations Not known | | | |
| **Is English Spoken?**  Yes  No | | | |
| **Military Connection** | | | |
| Yes, Serving  Yes, Veteran  Yes, Carer relationship  No  Not known  Prefers not to say | | | |
| **Permanent Address:** |  | | |
| **Postcode:** | | | |
| **Gender**  Male  Female  Transgender F to M  Transgender M to F Prefers not to say  Other (specify) | | | |
| **Sexual Orientation** | | | |
| Lesbian  Gay Man  Heterosexual  Bisexual  Questioning  Not known  Prefers not to say Other (specify) | | | |
| **Marital or Civil Partnership Status** | | | |
| Single  Separated (but still legally married / in civil partnership)  Co-habiting  Divorced or Civil Partnership Dissolved  Married  Widowed  In Civil Partnership  Surviving partner of Civil Partnership  Not known  Prefers not to say | | | |
| **Religion or Belief** | | | |
| Buddhist  Christian (all denominations)  Hindu  Jewish  Muslim  Sikh  No Religion  Not known  Prefers not to say  Other (specify) | | | |

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| **Ethnic Background** | |
| **White**  British  Irish  Gypsy or Irish Traveller  Any other White background (specify)    **Mixed Ethnic Groups**  White & Black Caribbean  White & Black African  White & Asian  Any other Mixed ethnic background (specify)    **Black / Black British**  African  Caribbean  Any other Black/African/Caribbean background (specify) | **Asian / Asian British**  Indian  Pakistani  Bangladeshi  Chinese  Any other Asian background (specify)    **Other Ethnic Group**  Arab  Any other ethnic group (specify)    Ethnicity not known  Prefers not to say |
| **Does the Client identify themself as Cornish?** Yes  No  Not known | |
| **Does the Client consider themselves to have a disability?** | |
| Yes  No  Not known  Prefers not to say | |
| **What types of disability or impairment does the Client have?** Select **ALL** that apply | |
| Mental Health Condition  Acquired Brain Injury  Physical Disability  Serious Physical Illness  Sensory (Hearing)  Learning Disability  Sensory (Sight)  Dementia / Alzheimer’s  Asperger's / Autism Spectrum Condition  Unconsciousness  Cognitive Impairment  Other (specify) | |

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| **Client Location Details** | |
| **Client’s current location:**  Own Home  Dementia Ward  Hospital  Own Home with Support  Care / Nursing home  Homeless  Supported Living  Prison  No Fixed Abode  Acute Psychiatric Unit  Forensic Secure Unit  Other Institution | |
| **Is Client currently at their permanent address?**  Yes  No (If No, give details below) | |
| **Current Address:** |  |
| **Postcode:** | |
| **Telephone No.** | |

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| **Community DoLS/1.2 Rep Referral Details** | | |
| **Please confirm which of the following documents have been attached:** | | Current care and support plan  Draft COP11 |
| **Please indicate if this is a:**  First Referral  Renewal | | |
| **Please give details of any known risks the advocate should be aware of**  If you are not aware of any risks, please write ‘no known risks’ | | |
| **Who should we contact to make arrangements to visit the client?**  Name:  Role:  Contact number(s):  Email address: | | |
| **In preparing an application to the Court, the expectation is that the 1.2 Rep will:** | | |
|  | * Have initial discussion with professionals and visit the client * Attend a Best Interests meeting *(N.B. if this has already taken place, the 1.2 Rep should be provided with the minutes and most recent care and support plan)* * Prepare a COP24 Witness Statement * Prepare the COP11 Annex C | |
| Whilst awaiting the Court Order, some Local Authorities (e.g. Kent) require regular client contact / visits (normally 6-8 weekly). Please check this box if this is a requirement  and indicate frequency here: | | |
| Whilst the Court Order is in place, the 1.2 Rep will make regular contact / visits every 6-8 weeks unless otherwise specified here: | | |
| Around 8 weeks prior to the end of the Court Order, the 1.2 Rep will notify the applicant authority that a further referral is needed to begin the renewal work and a new case will be created. | | |
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**Declaration:**

* I declare that I wish to instruct a Community DoLS/1.2 Rep.
* I am providing this information and making this referral in relation to the Mental Capacity Act 2005.
* In accordance with current Data Protection legislation, I agree to The Advocacy People and their delivery partners holding personal information (including information on this form).
* I understand the provision of an advocacy service is subject to the client meeting eligibility criteria.

**Please e-mail the completed form to** [info@theadvocacypeople.org.uk](mailto:info@theadvocacypeople.org.uk)

or post to P.O. Box 375, Hastings TN34 9HU

If you have not received confirmation of this referral within 2 working days, or you would like to discuss any aspects of a referral, please call **0330 440 9000**

By requesting advocacy support, you give consent to The Advocacy People sharing information, as required for the purposes of providing the service. For more information on our Privacy Policy, please ask your advocate or go to [www.theadvocacypeople.org.uk/privacy](http://www.theadvocacypeople.org.uk/privacy)

**Confidentiality:**

Communications between you and The Advocacy People are confidential. We will not divulge any information without your permission unless disclosure is required or permitted by law, e.g. where you tell us something which leads us to believe you or someone else may be at risk of serious harm or abuse or committing a serious criminal offence, where there is a court order for disclosure, or where we would be breaking the law by failing to disclose.

All records are held by The Advocacy People in accordance with current Data Protection legislation.