**Independent Health Complaints advocacy referral form**

To provide guidance, to empower and support people who wish to make a complaint about the service they have received from the NHS, whether directly provided or commissioned by the NHS.

**Referrals can only be accepted from residents of Stoke-on-Trent or Staffordshire.**

**ABOUT YOU:**

|  |  |
| --- | --- |
| **Details of the person making the complaint (complainant)** | |
| **Name** |  |
| **Date of Birth** |  |
| **Current address (including postcode)** |  |
| **Phone Number(s)** |  |
| **Email** |  |
| **Preferred method of communication** | Telephone.   * Do we have permission to leave a message? Yes / No   Text  Email  Written (post) |

|  |  |
| --- | --- |
| **Details of the patient (if different from the above)** | |
| **Name** |  |
| **Date of Birth** |  |
| **Current address (including postcode)** |  |
| **Telephone** |  |
| **Email** |  |
| **Preferred method of communication** | Telephone   * Do we have permission to leave a message? Yes / No   Text  Email  Written (post) |
| **Relation to patient?** | |

|  |  |
| --- | --- |
| **If you are a professional making the referral** | |
| **Name** |  |
| **Job title** |  |
| **Organisation/ team** |  |
| **Telephone** |  |
| **Email** |  |
| **How did you hear about us:** |  |

**ABOUT THE PERSON:**

|  |  |
| --- | --- |
| **Disability or impairment** | Learning disability  Mental health condition  Cognitive impairment  Physical health  Autistic spectrum disorder  Serious physical illness |
| **How does the person communicate?** | English  Other spoken language, **please specify:**  British Sign Language  Words/pictures/Makaton  Gestures/expressions/vocalisations  No obvious means of communication  Not listed, **please specify:** |
| Any additional support needs, **please specify**: | |

**REFERRAL INFORMATION:**

|  |  |
| --- | --- |
| **Details of the complaint** | |
| Hospital(s)  GP practice  Mental health services  Other health care professional, **please specify:** | West Midlands Ambulance  SDUC out of hours GPs  Community health/ health centre(s) |
| Please provide name(s) and dates of the issue: | |

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| --- | --- | --- |
| **Issue being complained about (please tick all that apply)** | | |
| Attitude of staff | Waiting times | Care and Treatment |
| Other, **please specify**; | | |
| **Further relevant information** | | |
| Please provide details and a brief explanation about your complaint: | | |

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| **Significant dates** |
| Please provide details for any impending meetings or deadlines: |

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| **Risks** |
| Are there any risks pertaining to the person (or their family/friends)? Are there any risks relating to an advocate visiting the person where they live? |
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| **Diversity monitoring** | |
| By completing the information below you can help us ensure our services reach everyone who needs them and inform how we might improve our service provision. | |
| **Gender** | Female  Male  Female, Male at birth  Male, Female at birth  Non-binary  Prefer not to say  Not listed, **please specify**: |
| **Pronouns** | She/her  He/him  They/them |
| **Sexual orientation** | Heterosexual  Bisexual  Lesbian or gay  Prefer not to say  Not listed, **please specify:** |
| **Ethnic origin** | Arab / British Arab  Asian / British Asian  Black / Black British  Gypsy / Roma / Traveller  Mixed heritage  White British – English, Welsh, Scottish, N. Irish  White Irish  White other  Prefer not to say  Not listed, **please specify:** |
| **Religion or belief** | Atheist (no religion)  Christian (all denominations)  Buddhist  Sikh  Hindu  Jewish  Humanist  Pagan  Muslim  Not listed, **please specify:**  Person’s own description: |
| **Does the person identify as having a disability or long-term health condition?** | |
| Yes No Please specify: | |

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| --- | --- | --- |
| **Consent** | | |
| Due to GDPR (2018), we need authorisation to say that people agree to Asist holding their personal information included on this form. | | |
| **I agree to Asist holding my personal information.** | Yes | No |
| If the person being referred is deemed to lack capacity, the referrer must indicate they are referring in the person’s best interest. | | |
| **Does the person have capacity to consent to this referral?** | Yes | No |
| **If yes, has consent been obtained?** | Yes | No |
| **Is the referral being made in best interest?** | Yes | No |

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| **Disclaimer** |
| **Please** note where possible, provide us with 2 weeks’ notice for any meetings to allow the advocate adequate time to support the person being referred. We may not be able to attend all meetings requested. |
| **Please** make sure information on this form is correct before submitting. |

**Please email completed form to: referrals@asist.co.uk**