**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:**

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| **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) |

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| **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?** |

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

**ABOUT THE PERSON:**

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| **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:**

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| **Details of the complaint** |
| [ ]  Hospital(s)[ ]  GP practice[ ]  Mental health servicesOther 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**