

# NHS COMPLAINTS ADVOCACY

## Referral Form

If you have any queries about completing this form, please contact the **Advocacy Enquiry Desk** on **024 7669 7443** Ext **228**.

Please return the completed form by post, email or fax.

### FOR OFFICE USE ONLY

Date referral received:

Date acknowledgement sent:

Date of referral (dd / mm / yyyy):

Do you have the client's consent to refer?:

Yes  No

*To be completed by agencies ONLY*

Initial contact will be made with the client within our standard five working days timescale. If a quicker than standard contact is required, please state the reason below:

## Contact details of the person making the complaint

*Please complete ALL sections in full*

Title:

Mr  Mrs  Ms  Other \_\_\_\_\_

Forename:

Surname:

Address:

Town:

Postcode:

Are you?

The Patient

The Patient's Representative

Telephone No:

Mobile No:

Email Address:

Gender:

Male  Female

Transgender

Date of Birth (dd/mm/yyyy):

Ethnic origin:

How would you prefer to be contacted?

Post

Telephone

Mobile

Email

Please specify any communication difficulties (e.g. hearing or speech):

*Continued on separate sheet*

Please specify any additional support issues (e.g. mental health issues):

*Continued on separate sheet*

# Who are you making your complaint against?

Organisation:

Address:

Town:

Postcode:

Title:

Mr  Mrs  Ms  Other \_\_\_\_\_

Forename:

Surname:

Telephone No:

Mobile No:

Email address:

## Please summarise the complaint below

*Continued on separate sheet*

At the completion of the case, client feedback will be sought where possible in order to monitor the quality of our service. Feedback may also be requested from referrers, where possible

# Risk Assessment

This **MUST** be completed in full before a referral can be accepted  
*Please continue on a separate sheet if necessary, indicating below if you have done so*

Is the client likely to be a risk to the staff member when visiting their home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client likely to be a risk to themselves?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the meeting venue or environment likely to be a risk to the staff member? If Yes, please state the danger.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will there be anyone else there when the staff member visits? If yes, whom?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a reason that the client cannot be visited by one person? If yes, please explain the risk in full and specify alternative arrangements.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any drug and/or alcohol issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a history of verbal aggression?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a history of physical aggression?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a forensic history with this client?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any pets in the house? If so, what type? The client may be asked to put the pet(s) in another room during the visit.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any other risk factors that we should know about? If Yes, what are they?	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Continued on separate sheet*

# Equal Opportunities Monitoring

## Gender

(Please tick only one box)

Prefer not to answer

Male

Female

Transgender

## Sexuality

(Please tick only one box)

Prefer not to answer

Heterosexual  
/ Straight

Gay /  
Lesbian

Bisexual

Other

## Marital Status

(Please tick only one box)

Prefer not to answer

Single

Married /  
Civil Partnership

Separated

Divorced

Widowed

## Age

(Please tick only one box)

Prefer not to answer

16-24

25-34

35-44

45-54

55-64

65-74

75-84

85-94

95+

## Ethnic Origin

(Please tick only one box)

White: British

Aisan/Asian British: Bangladeshi

Black/Black British: African

White: Irish

Aisan/Asian British: Chinese

Black/Black British: Caribbean

White: European

Aisan/Asian British: Indian

Other Black background

Other White background

Aisan/Asian British: Japanese

Other ethnic group

White and Asian

Aisan/Asian British: Pakistani

White and Black African

Other Asian background

White and Black Caribbean

Other mixed background

Prefer not to answer

## Religion or Belief

(Please tick only one box)

Prefer not to answer

Buddhist

Christian

Hindu

Jewish

Muslim

Sikh

No Religion

Other

## Disability

Prefer not to answer

The Equality Act 2010 defines a disability as a "physical or mental impairment which has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities". An effect is long-term if it has lasted, or is likely to last, more than 12 months.

Do you consider that you have any of the following disabilities under the Equality Act?

(Please tick those that apply)

Blindness / Partial Sight Loss

Learning Difficulty (e.g. dyslexia)

Mental Health Condition

Deafness / Partial Hearing Loss

Learning Disability

Physical Disability

Developmental disorder  
(e.g. Autism, Spectrum Disorder, etc.)

Long-term illness, disease or  
condition

Any other condition(s)