**NHS Complaints Advocacy Referral form**

**Please note client name and client date of birth are mandatory fields. Failure to complete all relevant parts of the form may result in delaying the appointment of an advocate.**

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| **Complainant Details:** |
| **First name:**  |       |
| **Last name:** |       |
| **Title:** |       |
| Preferred pronouns: *(i.e. She/He/They)* |       |
| **Date of birth:** *(DD/MM/YYYY)* |       |
| **Do you have any communication needs?** *(please select all that apply)* |
| **Audio** | **[ ]**  | **Braille** | **[ ]**  |
| **BSL interpreter**  | **[ ]**  | **Easy read** | **[ ]**  |
| **ESL** | **[ ]**  | **Gestures/facial expressions** | **[ ]**  |
| **Interpreter required** | **[ ]**  | **Large print** | **[ ]**  |
| **Manual alphabet** | **[ ]**  | **Minicom** | **[ ]**  |
| **Moon** | **[ ]**  | **Pictures/Symbols/Makaton** | **[ ]**  |
| **No obvious means** | **[ ]**  | **No communication needs** | **[ ]**  |
| **Home address line 1:** |       |
| **Address line 2:** |       |
| **Address line 3:** |       |
| **Town:** |       |
| **County:** |       |
| **Postcode:** *(Please add a space between the first half of the postcode and the second i.e. AA1 2BB)* |       |
| **Mobile number:** *(Do not use spaces)* |       |
| **Landline number:** |       |
| **Email:**  |       |
| **Do you have a preferred time/day for us to contact you?** |       |
| **Preferred method of communicating:** *(e.g Landline, mobile, email, post, video call)* |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Are you complaining on behalf of someone else?** | **Yes** | [ ]  | **No** | [ ]  |
| **If you are complaining on behalf of someone else please complete the below** |
| **Patient first name:** |       |
| **Patient last name:** |       |
| **Patients preferred pronouns:** *(i.e. She/He/They)* |  |
| **Patient date of birth:** *(DD/MM/YYYY)* |       |
| **Your Relationship to Patient:** |       |

|  |
| --- |
| **Complaint details** |
| **NHS Care Provider complaint is about:** *(e.g: GP Surgery, Hospital, PCT)* |       |
| **Name and role of NHS Staff involved in complaint:** |       |
| **Brief outline of issue:** |
|  |
| **When did the treatment/incident happen?** *(day/month/year)* |  |
| **Are there any meetings upcoming?** | **Yes** | [ ]  | **No** | [ ]  |
| **If yes, please specify dates:** |  |

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| **If you are a professional making a referral on behalf of someone else** *(e.g. Healthwatch / other support agency)****,* please provide your details below:** |
| **Referrer name:** |  |
| **Referrer job title:** |  |
| **Referrer department:** |  |
| **Referrer organisation:** |  |
| **Referrer email:** |  |
| **Referrer landline:** |  |
| **Referrer mobile:** *(Do not use spaces)* |  |

**Please now complete the monitoring form on the next page.**

**Person’s Monitoring Information**

|  |
| --- |
| **Ethnicity** |
| **Asian/Asian British** | **Black/ Black British** | **Mixed** | **White** |  |
| Bangladeshi | [ ]  | African | [ ]  | British | [ ]  | British | [ ]  | Client declined | [ ]  |
| Chinese | [ ]  | Caribbean | [ ]  | Asian /White | [ ]  | Irish | [ ]  | Not known by referrer | [ ]  |
| Indian | [ ]  | Somali | [ ]  | Black African/ White | [ ]  | Scottish | [ ]  | Other please state: |       |
| Pakistani | [ ]  | Other Black/ Black British | [ ]  | Black Caribbean/ White | [ ]  | Welsh | [ ]  |  |
| Other Asian/Asian British | [ ]  |  |  | Other Mixed background | [ ]  | English | [ ]  |
|  |  |  |  |  |  | Gypsy/ Traveller | [ ]  |
|  |  |  |  |  |  | Other White | [ ]  |  |  |

| **Gender** | **Sexual Orientation**  | **Religion** |
| --- | --- | --- |
| Female | [ ]  | Bisexual | [ ]  | Buddhist | [ ]  |
| Male | [ ]  | Gay male | [ ]  | Christian/ Catholic | [ ]  |
| Intersex | [ ]  | Lesbian | [ ]  | Hindu | [ ]  |
| Transgender | [ ]  | Heterosexual | [ ]  | Jewish | [ ]  |
| Gender Non-Binary | [ ]  | Pansexual | [ ]  | Muslim | [ ]  |
| Gender Fluid | [ ]  | Asexual | [ ]  | Sikh | [ ]  |
| Other, please state: |       | Other, please state: |       | Pagan | [ ]  |
| Client declined | [ ]  | Client declined | [ ]  | No Religion | [ ]  |
| Not known by referrer | [ ]  | Not known by referrer | [ ]  | Other, please state: |       |
|  |  |  |  | Client declined | [ ]  |
|  |  |  | Not known by referrer | [ ]  |

| **Client Group***(please tick all relevant)* |
| --- |
| Acquired brain injury | [ ]  |
| Autism/Asperger’s  | [ ]  |
| Cancer | [ ]  |
| Carer | [ ]  |
| Cognitive Impairment | [ ]  |
| Dual Sensory disabilities - Deaf and Blind | [ ]  |
| Hearing – Deaf – Severe hearing impairment | [ ]  |
| Hearing – Hard of hearing | [ ]  |
| HIV/Aids | [ ]  |
| HM Forces currently serving | [ ]  |
| Homeless | [ ]  |
| Learning disability/difficulty | [ ]  |
| Long term illness/condition | [ ]  |
| Marriage or civil partnership | [ ]  |
| Mental health | [ ]  |
| Mental health - Dementia | [ ]  |
| Mental health – Older peoples | [ ]  |
| Older person | [ ]  |
| Physical disability | [ ]  |
| Pregnancy/Maternity | [ ]  |
| Prisoner | [ ]  |
| Returning Citizen (Ex Offender) | [ ]  |
| Sensory impairment - Learning | [ ]  |
| Stroke | [ ]  |
| Substance misuse | [ ]  |
| Substantial difficulty | [ ]  |
| Transition - Child to Adult Services | [ ]  |
| Unconscious | [ ]  |
| Veteran | [ ]  |
| Vision – Blind – Severe visual impairment | [ ]  |
| Vision – partially sighted | [ ]  |
| Client declined / prefer not to say | [ ]  |
| No disability | [ ]  |
| Other please state:       |

**You can return this form to us by:**

Email: NHSComplaints@pohwer.net

Fax: 0300 456 2365 or

Post: PO Box 17943, Birmingham, B9 9PB

If you have any queries about completing this form please call us on **0300 456 2370**.