

**Croydon Health Complaints Advocacy Referral & Consent Form**

|  |  |
| --- | --- |
|  **Health Complaints** **Advocacy can:*** Help you to complain about any NHS funded service you have received
* Support you to write letters or attend meetings about your complaint
* Provide templates and guidance for you to make your own complaint
* Give you information about where and who to complain to

\*\* **You must live within the borough of Croydon** to receive Health Complaints Advocacy. The **NHS service that you complain about does not have to be within the Borough of Croydon**. |  |
| I:\lores_images\Telephone.jpg  | If you **need help** with this form call us on **0345 310 1812 option 1** |
|  | Monday to Friday between 9am and 5pm |
| I:\lores_images\Formhelp2.jpg | Or you can ask **someone you trust to help** you |
|    | Find this referral form at <https://advocacyforcroydon.org/> |    | Send your completed referral form to referrals@advocacyforall.org.uk  |
|    | Advocacy for All, St Helier Community Centre, Hill House, Bishopsford Road, SM4 6BL |

|  |
| --- |
|   **About you**  **)** |
|  |
| Name |  Click or tap here to enter text. | Date of birth |  |
| Address |  Click or tap here to enter text. | Age |  Click or tap here to enter text. |
|   | Gender |  |
|   | please tell us if you have any needs we | Click or tap here to enter text. |
| I:\lores_images\Telephone.jpgTel |  Click or tap here to enter text. | should know about |
| I:\lores_images\TextMessage.jpgMobile |  | emailaddress |  |
|  |  |  |  |

|  |
| --- |
| Ethnicity: Choose an item. |
| Sexuality: Choose an item. |
| Religion/Faith: Choose an item.Main disability, if any: Choose an item.Second disability, if any: Choose an item.If other, please say: Click or tap here to enter text. |

|  |
| --- |
| **If you are the person making the complaint, but are not the patient, please fill in the following sections** |
| your name |  Click or tap here to enter text. | has the person agreed to this complaint proceeding?(Yes/No/Deceased) |  Click or tap here to enter text.  |
| your address (if different)  |  Click or tap here to enter text. |
|   |
|   | your relationship to the person | Click or tap here to enter text. |
| I:\lores_images\Telephone.jpg tel |  Click or tap here to enter text. |  |
| I:\lores_images\TextMessage.jpg mobile |  Click or tap here to enter text. | please tell us if you have any needs weshould know about  | Click or tap here to enter text. |
| email | Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of NHS service you wish to complain about  | Click or tap here to enter text. | Address | Click or tap here to enter text. |
| Name of NHS staff member, department, etc. if relevant | Click or tap here to enter text. |
| I:\lores_images\Telephone.jpg  | Click or tap here to enter text. |
|  |   | Click or tap here to enter text. |
| I:\lores_images\InformationSign.jpg | Please write as much as you can about the **complaint** here. It is helpful to include **when & where** the incident happened & **who was involved**.      |

|  |  |
| --- | --- |
| I:\lores_images\Decision.jpg | **What outcome do you expect from the complaints procedure?**(e.g. \*an apology \*an explanation \*answers to specific questions \*action to put things right \*an assurance that the same things won’t happen to someone else)Click or tap here to enter text. |

|  |  |
| --- | --- |
| Further Information: |  |

|  |
| --- |
| **Consent Form**The **Data Protection Act** says we need to make sure you agree that we can **keep personal information** on you.This form will be given to everyone with whom your advocate liaises about your complaint, to provide evidence to them that you wish the advocate to support you.**CONFIDENTIALITY STATEMENT**: Advocacy for All is a confidential service; anything that you tell us will be kept confidential unless you tell an Advocacy for All advocate something which leads him or her to believe that you intend to cause harm to yourself or that of another person. In this case the advocate will discuss the case with their line manager after discussing the implications with you.All records are kept in accordance with Data Protection legislation |
|  |

**This box is also to be completed by a representative of the patient if that person is complaining about the service or treatment the patient received** (rather than the patient making their own complaint)

Your name: ……………………………………………………………………

Has the patient agreed to this complaint proceeding and you making the complaint on their behalf? **YES / NO / DECEASED**

**Your address if different to the patient’s**

………………………………………………………………

……………………………………………Post code:

**Your relationship to the patient:**

………………………………………

**If applicable, patient to sign here:**

……………………………………….

**About the Person**

**Name:**

**Address:**

**Date of birth:**

Patient – please sign this declaration to confirm that you would like the support of an advocate to complain about a service or treatment you received.

I authorize Advocacy for All to work with me, liaise with appropriate others about my complaint, and to request, receive and hold any information as may be relevant to my complaint.

**Advocacy for All is an Independent Advocacy Organisation**

**Charity No: 1068455 Company No: 3407428**

Signature:………….……………………………Date:………..………………