

**Havering Statutory Independent Advocacy Service**

**NHS Complaints Referral Form**

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| **Date of referral:** |  |
| **Client name:** |  |
| **Date of Birth:** |  |
| **Gender:** | Choose an item. |
| **Permanent address:** |  |
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|  |
| **Telephone Number:** |  |
| **Mobile Number:** |  |
| **Email address:** |  |
| **Where did you hear about the service?** | Choose an item. |

**Monitoring Details:**

|  |  |
| --- | --- |
| **Client Religion:** | Choose an item. |
| **Client Sexuality:** | Choose an item. |
| **Client Ethnicity:** | Choose an item. |
| **Do you have a disability?** | Choose an item. |
| **If yes, please state:** |  |

**Please provide further details regarding your complaint:**

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| --- |
| *Continue on separate sheet if necessary* |

**Are There Deadlines / Important Dates Relevant to the Issue/s?**

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## **Communication Needs**

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| --- | --- | --- | --- | --- |
| **Do you have any communication needs? (Please select)** | **Yes** | [ ]  | **No** | [ ]  |
| If so please describe:  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **If complaining on behalf of someone, have they provided consent for this referral to be made?** **(Please select)** | **Yes** | [ ]  | **No** | [ ]  |
| **If no, please provide further information:** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name or Signature of referrer** |  | **Date** |  |

Please email your referrals form to advocacy@haveringmind.org.uk

Telephone: 01708 457040