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| **Southern Advocacy Service – IMCA – REFERRAL FORM** | | | | | | | |
| **Name of Person:** |  | | | | | For IMCA use: |  |
| **Date of Referral:** |  | **Gender:** |  | **Age:** |  | **Date of Birth:** |  |
| **Current Location or Home Address:** |  | | | | | | |
| **Telephone number:** |  | | | | | | |

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| **Issue Details** | Serious Medical Treatment: |  | Care Review: |  |
| Change in Accommodation: |  | Adult Protection\*: |  |
| Give detailed information (continue separately if required): | | | \*Adult protection referrals **must**  be open to safeguarding | |
|  | | | | |
| **For Safeguarding Referrals ONLY:**  Please give details of the concerns raised and any planned interventions by the Safeguarding team: | | | | |

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| **Significant Dates / Information** | |
| Details of any impending meetings or deadlines: |  |
| How does the client communicate? |  |
| Specific Needs (access issues, etc): |  |
| **Local Authority** - or - **NHS/PCT body** [please identify] | |

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| **Others involved** | | | | |
| **Is this client befriended?** | Yes | / | No | (See MCA Code 10.74 to 10.80 – Who is ‘appropriate to consult’) |
| Details of professionals / others involved, give contact details (continue separately as required): | | | | |

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| **Date of Mental Capacity Assessment:** |  |
| **Name of Mental Capacity Assessor:** |  |
| **Decision for which an IMCA is required:** |  |

IMCA’s can only be instructed for people who have been assessed as lacking capacity to make a specific decision.

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| **Decision Maker Name:** | |  | | | |
| Job Title: |  | | | Phone No: |  |
| Address &  Postcode: |  | | | | |
| Email: |  | | | | |
| **Referrer Name** (if different): | | |  | | |
| Job Title: |  | | | Phone No: |  |
| Address & Postcode: |  | | | | |
| Email: |  | | | | |

IMCA MONITORING INFORMATION REQUIRED BY THE DEPT OF HEALTH

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| **Nature of Impairment:** | | | | | |
| Unconsciousness |  | Serious Physical Illness |  | Learning Disability |  |
| Autism Spectral Condition |  | Acquired Brain Injury |  | Cognitive Impairment |  |
| Mental Health Problems |  | Dementia |  | Combination |  |
| Other (please specify): |  |  | | | |

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| **Ethnic Background:** | | | | | | | |
| **White:** | | **Black / British:** | | **Asian / British:** | | **Mixed:** | |
| White British |  | Black Caribbean |  | Indian |  | White & Black Caribbean |  |
| White Irish |  | Black African |  | Pakistani |  | White & Black African |  |
| Other White\* |  | Other Black\* |  | Bangladeshi |  | White & Asian |  |
|  | | | | Other Asian\* |  | Other Mixed White\* |  |
| **Other ethnicities:** | | Chinese |  | Other |  | Not Known / Stated |  |
| \*Specify Other: | |  | | | | | |

By signing this referral, you are officially instructing an IMCA. You are also consenting that you are authorised by the NHS/ CCG or Local Authority responsible for the decision being made.

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| **PRINT NAME:** |  | | |
| **SIGNATURE:** |  | **DATE:** |  |

Please email completed referrals to: [jan@southernadvocacyservices.co.uk](mailto:jan@southernadvocacyservices.co.uk)

Or, confidentially fax it to: 08443588877

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| **FOR ADVOCATE USE ONLY** | |
| What is the person’s (being referred) ‘expected outcome/s’ from the advocate? |  |
| At the end of the advocates work, did the person being referred feel their ‘expected outcome/s’ were met by the advocate? | **YES / NO** |
| If no, please explain why: |  |