**IMCA and Care Act Advocacy
Referral Form**

**Email to: Advocacyhub@mindinsalford.org.uk**

|  |
| --- |
| Note: if the client is being referred for Community, IMHA or NHS Complaints Advocacy please use the alternative form  |
|  |
| **Client** |
| Name | Date of Referral |
| Current Location  | Previous/Home Address (if applicable) |
| Telephone Number | Email Address |
| Date of Birth | Gender |
|  |
| Is the client a Carer? | **Yes** |  | **No** |  |
| **Decision Being Made** |
| Serious Medical Treatment  |   | Initial Enquiry  |   |
| Local Authority Change of Accommodation  |   | Needs Assessment or Care Planning  |   |
| NHS Body Change of Accommodation |   | Care Review |   |
| Deprivation of Liberty |   | Safeguarding Enquiry or Review |  |
| Please provide more information about the decision and current stage of the process |
| Upcoming dates and deadlines |
|  |
| **Capacity and Substantial Difficulty** |
| Does the person lack capacity or have a substantial difficulty in one or more of the following areas  |
| Understanding Relevant Information |  Lacks Capacity |   | Substantial Difficulty  |   |
| Using and Weighing Information |  Lacks Capacity |   | Substantial Difficulty  |   |
| Retaining Information  |  Lacks Capacity |   | Substantial Difficulty  |   |
| Communicating Views, Wishes and Feelings |  Lacks Capacity |   | Substantial Difficulty  |   |
| Please explain the difficulty or capacity issue further.  |
| Has a capacity assessment been made in regards to this specific decision? | Yes |   | No |   |
| Name and role of the person making the assessment |   |
| Date the assessment was completed |   |
|  |
| **Primary Means of Communication** |
| English |   | Gestures / Facial Expressions / Vocalisations |   | No Obvious Means of Communication  |   |
| Other Spoken Language |   | British Sign Language |   | Words / Pictures / Makaton |   |
| Other (Please State) |   |
|  |
| **Appropriate Person** |
| Does the client have someone appropriate to consult? | Yes |   | No |   |
| Can the person support the client appropriately through the process? | Yes |   | No |   |
| If no to either, please explain why they are deemed to be inappropriate to consult, or not willing or able to be consulted and provide support throughout the process |
|   |
| **Client Group** |
| Mental Health |   | Physical Health  |  | Sensory |   | Learning Disability |   |
| Over 60 |   | Dementia |  | Autism |   | Other |   |
|  |
| **Client Medical Details** |
| Any relevant medical details (Please give details on the client group above) |
|
|  |
| GP Name | Practice Address |
| Telephone Number |
|  |
| Does the person present any **risk** of harm to themselves or others *(please detail)* | **Yes** |  | **No** |  |
| Risk Details (please include anything that may affect potential home visits) |
|  |
| **Referrer**  |
| Agency (including department or team) | Worker Name |
| Position | Relationship to Client |
| Telephone Number | E-mail |
| Will you be decision maker? | **Yes** |  | **No** |  |
| If no, please provide the name and the contact details of the **decision maker** |
| Agency (including department or team) | Worker Name |
| Position | Relationship to Client |
| Telephone Number | E-mail |
|  |
| Has the client provided their **consent** to be contacted by the advocate? | **Yes** |  | **No** |  |
|  |
| **Other People Involved,** including those appropriate to consult |
| (eg professionals, court appointed deputy, LPA, EPA, carers, family members, close friends etc) |
| Name | Position / Agency / Relation | Contact Details |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |