**IMCA and Care Act Advocacy   
Referral Form**

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

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| Note: if the client is being referred for Community, IMHA or NHS Complaints Advocacy please use the alternative form | | | | | | | | | | | | | | | | | | |
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| **Client** | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | Date of Referral | | | | | | | | | | | |
| Current Location | | | | | | | Previous/Home Address (if applicable) | | | | | | | | | | | |
| Telephone Number | | | | | | | Email Address | | | | | | | | | | | |
| Date of Birth | | | | | | | Gender | | | | | | | | | | | |
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| 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 | | | | | | | | | | | | | | | | | | |
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| **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 | | | | | |  | | | | | | | | | | | | |
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| **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 | | | | | | | | | | | | | | | | | | |
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| **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) | | | | | | | | | | | | | | | | | | |
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| 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) | | | | | | | | | | | | | | | | | | |
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| **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 | | | | | | | | | | | |
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| 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 | | | | |
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