**Independent Mental Capacity Advocacy (IMCA) Referral Form**

Please complete this form in full and return it to: advocacy@ecstaffs.co.uk or return by post to: **Healthwatch Halton Advocacy HUB, Suite 5, Foundry House, Widnes Business Park, Waterside Lane, Widnes WA8 8GT**

If you need support to complete this form, please contact us on **0151 347 8183**

   **Section A: About the person**

|  |  |
| --- | --- |
| Name of person: |  |
| Date of Birth: |  |
| Current place of residence:  |  |
| NHS Number/Social Care Number:  |  |
| Telephone number: |  |
| Equal Opportunities form completed? Please tick |  Yes  | No  |

Section B: What is the Best Interest Decision? (Please tick)

|  |  |
| --- | --- |
| Serious Medical Treatment |  |
| Long Term Accommodation |  |
| For Long Term Accommodation, what is the projected discharge date? (DD/MM/YY) |
| Adult Protection |  |
| Care Review |  |
| Please describe the decision: |
| Date decision needs to be made by: |
| Any other deadlines/ meeting dates (please specify including dates):  |

Section C: Capacity Assessment

|  |  |
| --- | --- |
| Has a capacity assessment been completed?  |  |
| Name of Assessor: |  |
| Designation (e.g. Social Worker): |  |
| Date of Assessment:  |  |

Section D: Family and Friends

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does the referred person have a family? Please tick | Yes |  |  No |  |
| Does the referred person have any friends? Please tick | Yes |  |  No |  |
| Are the person’s family appropriate to be involved in the best interest decision? | Yes |  |  No  |  |
| If no, what is the reason the family are not involved? |

Section E: Risk and Support Needs

|  |
| --- |
| Risks: Please detail any information relevant to ensuring the safety of the person or of the advocate (or both):  |
| Support Needs: Please detail any support needs the advocate will nee to provide support e.g. Language or preferred communication methods:  |
| Safeguarding: Please detail any existing safeguarding concerns that the advocate should be aware of: |

**Section F: Key People**

|  |  |  |
| --- | --- | --- |
|  | Professional making the best interest decision: | Referred (if different from decision maker) |
| Print name |  |  |
| Position |  |  |
| Organisation |  |  |
| Telephone No |  |  |
| Mobile No |  |  |
| Email |  |  |
| Fax No |  |  |
| Pager |  |  |
| Involved professionals (not listed above) and contact details:  |  |
| Is the referred person aware of the advocacy referral?  |   Yes |  No |
| Signature (Referrer) |  | Date:  |
| Signature (Decision Maker) |  | Date:  |

Please complete this form in full and return it to: advocacy@ecstaffs.co.uk or return by post to: **Healthwatch Halton Advocacy HUB, Suite 5, Foundry House, Widnes Business Park, Waterside Lane, Widnes WA8 8GT**

**For internal use only**

|  |  |
| --- | --- |
| Date referral received:  | Date first contacted:  |
| Date of appointment:  | Time of appointment: |
| Allocated advocate name: |

**EQUAL OPPORTUNITIES- PLEASE COMPLETE**

Do you consider the person you are referring as:

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Male | [ ]  Female | [ ]  Transgender | [ ]  Rather not say |

How would you describe their ethnic origin or background?

|  |  |  |
| --- | --- | --- |
| **Asian**[ ]  Indian[ ]  Pakistani[ ]  Bangladeshi[ ]  Any other Asian background (please write in) | **Black**[ ]  Caribbean[ ]  African[ ]  Any other Black Background (please write in) | **Chinese or other ethnic** **group**[ ]  Chinese[ ]  Any other Ethnic group(please write in) |
| **Mixed**[ ]  White & Black Caribbean[ ]  White & Black African[ ]  White & Asian[ ]  Any other Mixed background (please write in) | **White**[ ]  English[ ]  Irish[ ]  Scottish[ ]  Welsh[ ]  Any other White background (please write in) | [ ]  Rather not say |

Do you consider them to have the following?

|  |  |
| --- | --- |
| Physical/mobility impairment, such as a difficulty using your arms or mobility issues which require you to use a wheelchair or crutches |  |
| Visual impairment, such as being blind or having a serious visual impairment |  |
| Hearing impairment, such as being deaf or having a serious hearing impairment |  |
| Mental health condition, such as depression or schizophrenia |  |
| Learning disability/difficulty, such as Down’s syndrome or dyslexia or a cognitive impairment such as autistic spectrum disorder |  |
| Long-standing illness or health condition, such as cancer, HIV, diabetes, chronic heart disease or epilepsy |  |
| Other (Please specify below) |  |

How would you describe their sexuality?

|  |  |  |
| --- | --- | --- |
| [ ]  Bisexual | [ ]  Homosexual/Gay | [ ]  Rather not say |
| [ ]  Lesbian | [ ]  Heterosexual/ straight |  |

How would you describe their religious beliefs?

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  No Religion | [ ]  Baha’i | [ ]  Buddhist | [ ]  Christian |
| [ ]  Hindu | [ ]  Jain | [ ]  Jewish | [ ]  Muslim |
| [ ]  Sikh |  |  | [ ]  Rather not say |
| [ ]  Other (please write in) |       |  |

**Referral Receipt**

**Healthwatch Halton Advocacy HUB will confirm receipt of all IMCA referrals within 24 hours. If you have not received this confirmation, please contact us on 0151 347 8183 or** **advocacy@ecstaffs.co.uk**