**Independent Mental Health Advocacy IMHA**

Please complete this form in full and return it to: [advocacy@weareecs.co.uk](mailto: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: Patient Information**

|  |  |  |
| --- | --- | --- |
| Name: |  | |
| Date of Birth: |  | |
| Gender: |  | |
| Permanent Address: |  | Postcode: |
| Please describe the issue/ specific reasons why you are requesting IMHA support: | | |
| Are there deadlines/ important dates relevant to the issue/s? If yes, please specify: | | |

Where is the Patient Currently Detained/ Residing?

|  |  |
| --- | --- |
| Ward: |  |
| Hospital/ Care Home: |  |
| Address: |  |
| Postcode: |  |
| Telephone number: |  |
| Email address: |  |
| Does the patient have any communication needs? (please specify) |  |

Section B: How does the Patient Qualify for IMHA? (please tick and provide relevant date)

|  |  |  |
| --- | --- | --- |
| The patient is detained under section 2 of the Mental Health Act 1983: |  | Section start date: |
| The patient is detained under section 3 of the Mental Health Act 1983: |  | Section start date: |
| The patient is detained under part 3 of the Mental Health Act 1983 (‘forensic/ ‘forensic restricted;’ patients): |  | Section start date: |
| The patient is subject to a Community Treatment Order (CTO) under the Mental Health Act 1983: |  | Order start date: |
| The patient is subject to a Guardianship Order under the Mental Health Act 1983: |  | Order start date: |
| The patient is a voluntary/ ‘informal’ patient who may be given Section 57 treatment under the mental Health Act 1983: |  | Please provide details: |

**For Professionals**

|  |  |
| --- | --- |
| Has the patient provided consent for this referral to be made? | **Y/N?** |
| Has the patient been formally assessed or is it otherwise believed that they lack the mental capacity to consent to the referral being made? | **Y/N?** |
| Has the patient been formally assessed or is it otherwise believed that they lack mental capacity regarding the relevant issue/s? | **Y/N?** |
| Has the eligibility checklist been completed (For people not sectioned under the Mental Health Act)? | **Y/N?** |

|  |  |
| --- | --- |
| Please provide details of any risks or behaviours the Advocate needs to be aware of when dealing with the referral: | |
| Signature of referrer: | Date: |

**For internal use only**

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