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

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

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**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@weareecs.co.uk**](mailto:advocacy@ecstaffs.co.uk)