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| **Please note all fields must be completed or the form will be returned: this could delay an Advocate being allocated. Where Not Applicable please indicate by inserting N/A** |
| **The IMCA Service is provided for any person aged 16 or over, who lacks capacity to make a decision about either: a long-term change of accommodation; serious medical treatment; or a 6-8 review of accommodation following a change of accommodation and has no other appropriate person to support them.** |
| **Date of Referral** |
| **Client Details** |
| Client Name |  | Client DOB |  |
| Home Address |  |
| **Address at point of referral** (if different from above). If hospital, please include ward name/number |  |
| Post code |  | Local Authority/Borough |  |
| Telephone |  | Email |  |
| GP Surgery registered with |  | GP Surgery contact number |  |
| **Advocacy required (please tick only one box per referral)** |
| Serious Medical Treatment |  |
| Change of accommodation (over 28 days) |  |
| Review of Accommodation following an IMCA CoA  |  |
| Details (please provide as much additional information as you can about the referral |
|  |
| **Please ensure you complete this section in full** |
| Has a capacity assessment in relation to the decision being made been completed? | Yes/No |
| Does the capacity assessment indicate the person lacks capacity for this specific decision? Eg Change of Accommodation, serious medical treatment | Yes/No |
| Name & job title of person who completed the assessment |  |
| Date of assessment |  |
| Is the assessment attached with referral? | Yes/No |
| Please provide the details of the decision maker below |
| Name of Decision Maker |  |
| Job Title |  |
| Team and Department |  |
| Local Authority/Borough |  |
| Telephone |  |
| Email |  |
| Please detail any risk issues the advocacy services needs to be aware of below, or confirm there are no known risks |
|  |
| **Name and details of person completing this referral form** |
| **Name** |  | **Job Title** |  |
| **Telephone No** |  | **Email** |  |
| **Relationship to client** |  | **Date** |  |
| **IMCA and Care Act referrals, can only be made by a Health or Social Care Professional. Signing this referral allows the service to process the client’s information, act on behalf of the client, create anonymised case studies and share anonymised case notes for advocacy qualification training purposes.** |
| **Additional information – Please tick those that apply** |

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| **Religion or spiritual belief** |
| Buddhist |  | Jewish |  | Other Religion |  |
| Christian |  | Muslim |  | No Religious Belief |  |
| Hindu |  | Sikh |  | Do not wish to answer |  |
| **Ethnicity** |
| Asian or Asian British - Any Other Asian Background |  | Mixed - Any other mixed background |  | White - Any Other White Background |  |
| Asian or Asian British - Bangladeshi |  | Mixed - White and Asian |  | White - British |  |
| Asian or Asian British - Indian |  | Mixed - White and Black African |  | White - Gypsy or Irish Traveller |  |
| Asian or Asian British - Pakistani |  | Mixed - White and Black Caribbean |  | White - Irish |  |
| Black or Black British - African |  | Do not wish to answer |  | Not provided |  |
| Black or Black British - Caribbean |  | Other Ethnic Group - Any other ethnic group |  | Do not wish to answer |  |
| Black or Black British - Other Black Background |  | Other Ethnic Group - Arab |  |  |
| **Sexual orientation** |
| Heterosexual / Straight |  | Bisexual |  | Not Provided |  |
| Homosexual / Gay Man |  | Other |  |  |
| Lesbian / Gay Woman |  | Do not wish to answer  |  |  |
| **Additional needs** |
| Learning Disability |  | Mental Illness |  | Dementia |  |
| Autism |  | Acquired Brain Injury |  | Other |  |
| **Communication needs / preferences** |
| Preferred language (please specify) |  | English language |  | Other spoken language (please specify) |  |
| Preferred method of communication (please specify) |  | Able to read |  | British Sign Language |  |
| Pictures / symbols |  | Makaton |  | Gestures / facial expressions |  |
| Sounds / vocalisations |  | No formal means of communication |  | Other support needs |  |
| Hearing impairment |  |  |
| **Other** |

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| --- | --- | --- | --- |
| Gender |  | Identifies as same sex as at birth | Yes/No/Prefers not to answer |
| Marital status |  |

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| --- |
| Pregnant /maternity Yes/No |
| Mental health diagnosis: |
| **Please return this referral to:**essexadvocacy@rethink.org0300 790 0559 |