The IMCA Service is provided for any person aged 16 years or older, who has no one able to support and represent them, and who lacks capacity to make a decision about either: a long term care move; serious medical treatment; adult protection procedures; or a care review. OPG606 / MCA

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Client Details | | | | | | |
| Name |  | | | Known as |  | |
| Date of birth |  | | | Gender |  | |
| Address of current location |  | | | | | |
| postcode |  | | | Telephone no. |  | |
| Staff contact name at current address | |  | | | | |
| Home address (if different from above) |  | | | | | |
| postcode |  | | | Telephone no. |  | |
| Religion or spiritual beliefs |  | | | | | |
| Ethnicity | White British | | White Irish | | | White Gypsy / Irish Traveller |
| Other White background | | Black / Black British African | | | Black / Black British Caribbean |
| Other Black background | | Asian / Asian British Bangladeshi | | | Asian / Asian British Chinese |
| Asian / Asian British Indian | | Asian / Asian British Pakistani | | | Other Asian background |
| White / Asian | | White / Black African | | | White / Black Caribbean |
| Other mixed background: | | Other ethnic group: | | | |
| Additional needs | Learning Disability | | Mental Illness | | | Dementia |
| Autism | | Acquired Brain Injury | | | Other: |
| Communication needs / preferences | English language | | Other spoken language: | | | British Sign Language |
| Pictures / symbols | | Makaton | | | Gestures / facial expressions |
| Sounds / vocalisations | | No formal means of communication | | | Other: |

|  |  |  |  |
| --- | --- | --- | --- |
| Referrer Details | | | |
| Name |  | Job Title |  |
| Organisation / Service |  | Team |  |
| Address |  | | |
| Postcode |  | Telephone / mobile number |  |
| Email address |  | Secretary (if applicable) |  |
| Signature |  | | |
| Print name |  | Date referral made |  |
| By signing / submitting this referral form you are agreeing that the IMCA service can record and use **anonymised** case data for case studies, reporting to commissioners and for IMCAs to receive training assessment in line with providing an IMCA contract | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Decision Maker Details | | | |
| Name |  | Job Title |  |
| Organisation / Service |  | Team |  |
| Address |  | | |
| Postcode |  | Telephone / mobile number |  |
| Email address |  | Secretary (if applicable) |  |
| Signature |  | | |
| Print name |  | Date |  |

|  |  |  |
| --- | --- | --- |
| Is a current capacity assessment attached? | YES | NO |
| If no, please state the reasons why | | |

|  |  |  |  |
| --- | --- | --- | --- |
| About the Decision | | | |
| Tick one per referral | Serious Medical Treatment | Change of Accommodation | Care Review |
| **NOTE:** safeguarding referrals should be made under the Care Act | | | |
| Please provide a brief explanation for the advocacy referral | | | |
| Details of those who are appropriate to consult | | | |
| Details of those who are inappropriate to consult and why | | | |
| Best Interest Meeting dates: | | | |
| Deadline for IMCA report submission |  | Date decision to be made by |  |

|  |  |  |  |
| --- | --- | --- | --- |
| For IMCA service use | | | |
| Date referral received |  | IMCA assigned to case |  |
| RIS number |  | Person processing referral |  |

Email this form to: [essexadvocacy@rethink.org](mailto:essexadvocacy@rethink.org)

Send by post to: Rethink Advocacy, Saxon House, 27 Duke Street, Chelmsford, CM1 1HT

Telephone: 0300 790 0559

**General Data Protection Regulation (GDPR)** All records are kept in accordance with current GDPR legislation

For concerns or complaints regarding the referral please contact

Contract Manager:

Head of Service: Catherine Mercer: [catherine.mercer@rethink.org](mailto:catherine.mercer@rethink.org)