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

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| 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: |

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| 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 |

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| 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 |

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| 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 |  |

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

Email this form to: 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