Legal qualification for the IMHA service: those detained under the MHA: even if on leave from hospital, (excluding during short term holding powers), conditionally discharged restricted patients, those subject to Guardianship, those under Supervised Community Treatment (CTO) and informal or voluntary patients who are being considered for section 57 or section 58a treatments, including those who are under 18 years old and being considered for ECT. **The duty is on mental health service professionals, such as ward staff, to inform patients of their right to an IMHA**

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| Client Details |
| Name |  | Known as |  |
| Date of birth |  | Gender |  |
| Ward / 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 |  | Who should we contact to arrange initial appointment: |  |
| Signature |  |
| Print name |  | Date referral made |  |
| Has the Client consented to the referral?NOTE: If a referral is made without the permission of any patient who has the capacity to consent to advocacy; this breach of that patient’s confidentiality will be reported to the referring body’s Information Governance team in all cases. | Yes / No |
| If ‘no’, why is the client not aware of the referral? |
| Does the client lack the capacity to consent to a referral? **If yes, a Health or Social Care Professional must have consented to the referral by completing and signing in the box below.** This consent will allow 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 | Yes / No |
| **Consent is given by Nurse, Responsible Clinician, Doctor, Care Co-ordinator (Health/ Social Care Professional) detailed below** |
| Name |  | Job Title |  |
| Organisation / Service |  | Team |  |
| Address |  |
| Postcode |  | Telephone / mobile number |  |
| Email address |  | Secretary (if applicable) |  |
| Signature**(must be completed)** |  |
| Print name |  | Date |  |

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| About the Referral |
| Please add current info only | Section number / CTO / informal: | Date section started: | Renewal date: |
| Please provide a brief explanation for the advocacy referral |
| Are there upcoming meetings / hearings / MHRT dates that we need to be aware of? |
| Are there current risks we need to be aware of? |

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| For IMHA service use |
| Date referral received |  | IMHA 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