**IMCA Referral Form**

**What is the Independent Mental Capacity Advocate (IMCA) Service and how does it work?**

The purpose of the IMCA service is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about these decisions, or about care reviews or Adult Protection proceedings.

**The IMCA service safeguards the rights of people aged 16 years and over who:**

* lack capacity to make a specified decision at the time it needs to be made

The Mental Capacity Act 2005 (MCA) says everyone has the right to make their own decisions and must be given all practicable help to do so before they are deemed as lacking capacity. The person’s capacity must be assessed in relation to the decision to be made. Generic assessments of capacity are not sufficient.

*and*

* have nobody else who is willing and able to represent them or be consulted in the process of working out their best interests, other than paid staff

NHS and Local Authority Decision Makers need to determine if there are family or friends who are willing and able to be consulted about the proposed decision. If not, an IMCA will work with and support people who lack capacity, and represent their views to those who are considering their best interests in accordance with the MCA.

If a decision needs to be taken about a Care Review or Safeguarding case, there is now a statutory duty to refer under the Care Act 2014, and an ICAA referral should be made for an Independent Care Act Advocate.

**Please complete a SEPARATE referral PER REFERRAL REASON**

***If completing online, click once on relevant box to check. Write in text fields, where required.***

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| **Date of Referral:** | | | | | |
| **Professional Referrer’s Details** | | | | | |
| **Referrer First Name:** | | | | **Last Name:** | |
| **Organisation:** | | | | | |
| **Job Title or Relationship to Client:** | | | | | |
| Doctor | | Psychiatrist | | | Ward Manager |
| Care Manager | | Care Home Manager | | | Team Manager Health |
| Nurse / Health Professional | | Social Worker (Hospital) | | | Social Worker (Community) |
| Team Manager Social Care | | Administrator | | |  |
| Other / Non-Professional Relationship (specify) | | | | | |
| **Address:** |  | | | | |
| **Postcode:** | | | | | |
| **Tel No:** | | | **Mobile No:** | | |
| **Email:** | | | | | |

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| **Main Disability** Is there a **main** disability or impairment considered particularly relevant to this case? | | |
| Check **ONE** box only | | |
| Mental Health Condition  Physical Disability  Sensory (Hearing)  Sensory (Sight) | Asperger’s /Autism Spectrum Condition  Cognitive Impairment  Acquired Brain Injury  Serious Physical Illness | Learning Disability  Dementia / Alzheimer’s  Unconsciousness  **NO** |

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| **Client Information** | | | |
| **Title:**  Mr  Mrs  Ms  Other | | **First Name:**  **Last Name:** | |
| **Date of Birth:** | | | |
| **Permanent Address:** |  | | |
| **Postcode:** | | | |
| **Telephone No.** | | | **Mobile No.** |
| **E-mail** | | | |
| **Preferred method of contact:** | | | |
| Any  Telephone  E-mail  Post  Mobile Phone  Text  Cannot be contacted directly | | | |
| **Does the client consider themselves to have a disability?**  **Does the Client consider themself to have a disability?** | | | |
| Yes  No  Not known  Prefers not to say | | | |
| **What types of disability or impairment does the Client have?** Select **ALL** that apply | | | |
| Mental Health Condition  Acquired Brain Injury  Physical Disability  Serious Physical Illness  Sensory (Hearing)  Learning Disability  Sensory (Sight)  Dementia / Alzheimer’s  Asperger's / Autism Spectrum Condition  Unconsciousness  Cognitive Impairment  Other (specify) | | | |
| **What is the Client’s primary communication method?**  Spoken English  Other Spoken Language (specify)  British Sign Language (BSL)  Other (specify)  Words/Pictures/Makaton  No obvious means of communication  Gestures/Facial Expressions/Vocalisations Not known | | | |
| **Is English Spoken?**  Yes  No | | | |
| **Gender**  Male  Female  Transgender F to M  Transgender M to F Prefers not to say  Other (specify) | | | |
| **Does the Client identify themself as Cornish?** Yes  No  Not known | | | |

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| **Sexual Orientation** | | |
| Lesbian  Gay Man  Heterosexual  Bisexual  Questioning  Not known  Prefers not to say Other (specify) | | |
| **Ethnic Background** | | |
| **White**  British  Irish  Gypsy or Irish Traveller  Any other White background (specify)    **Mixed Ethnic Groups**  White & Black Caribbean  White & Black African  White & Asian  Any other Mixed ethnic background (specify)    **Black / Black British**  African  Caribbean  Any other Black/African/Caribbean background (specify) | | **Asian / Asian British**  Indian  Pakistani  Bangladeshi  Chinese  Any other Asian background (specify)    **Other Ethnic Group**  Arab  Any other ethnic group (specify)    Ethnicity not known  Prefers not to say |
| **Marital or Civil Partnership Status** |  | |
| Single  Separated (but still legally married / in civil partnership)  Co-habiting  Divorced or Civil Partnership Dissolved  Married  Widowed  In Civil Partnership  Surviving partner of Civil Partnership  Not known  Prefers not to say | | |
| **Religion or Belief** |  | |
| Buddhist  Christian (all denominations)  Hindu  Jewish  Muslim  Sikh  No Religion  Not known  Prefers not to say  Other (specify) | | |
| **Military Connection**  **oes the Client have a Military connection?** | | |
| Yes, Serving  Yes, Veteran  Yes, Carer relationship  No  Not known  Prefers not to say | | |

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| **Client Location Details** |
| **Client’s current location:**  Own Home  Dementia Ward  Hospital  Own Home with Support  Care / Nursing home  Homeless  Supported Living  Prison  No Fixed Abode  Acute Psychiatric Unit  Forensic Secure Unit  Other Institution |

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| **Is Client currently at their permanent address?**  Yes  No (If No, give details below) | |
| **Current Address:** |  |
| **Postcode:** | |
| **Telephone No.** | |
| **Ward Name (if in Hospital):** | |

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| **Advocacy Referral Details** | |
| Has the person been assessed to lack capacity to make a particular decision? | Yes  No |

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| **Please select ONE of the following** | |
| **Change of Accommodation**  Is a decision being made about long term care and health moves (more than 28 days in hospital / 8 weeks in a care home)? | Yes |
| **SMT**  Is the person facing a decision about serious medical treatment? | Yes |
| **Adult Protection**  Are there decisions relating to Adult Protection proceedings? | Yes |
| **Care Review**  Is there a care/accommodation review where it is felt that the person would benefit from IMCA? | Yes |

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| Are there any family and friends?  **or** is there anyone (other than paid workers) who are considered willing and appropriate to be consulted about the decision?  **(N.B. this does not apply for Adult Protection proceedings – people can have family and still be eligible)**  **If YES**, briefly describe any concerns about their involvement: | Yes  No |
| Is there an Advance Directive or any other form of record of the client’s wishes?  If YES, please give details: | Yes  No / Don’t know |
| Is this a first referral?  Yes  No  Not known | |
| **Please give details of any known risks the advocate should be aware of.**  If you are not aware of any risks, please write 'no known risks' | |
| **Details of Decision to be made** | |
| **Please give brief details:** | |
| **Date the decision needs to be made by:** | |
| **Details and dates of any meetings already arranged:** | |
| **Please summarise the steps taken to assess the lack of capacity (if known):** | |
| **Date of assessment \*** | |
| **Who carried out the assessment? \*** | |
| **Where are the notes held? \***  *\*This information is not essential at the referral stage* | |

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| **Details of Persons Relevant to the Referral** | | | | | | |
| **Is the Referrer the Decision Maker?** (the person ultimately responsible for this decision)  Yes  No **If No, please give details below:** (If Yes, go to Declaration) | | | | | | |
| **Decision Maker’s Details (if different from referrer)** | | | | | | |
| **First Name:** | | | | | **Last Name:** | |
| **Organisation:** | | | | | | |
| **Job Title:** | | | | | | |
| Doctor  Ward Manager  Care Manager  Care Home Manager  Nurse / Health Professional  Other (please state) | | | | | | |
| **Address:** |  | | | | | |
| **Postcode:** | | | | | | |
| **Work Tel No:** | | | | | | **Mobile No:** |
| **Email:** | | | | | | |
| **Is the Decision Maker aware of this referral?**  Yes  No | | | | | | |
| **Who can make arrangements for initial client meeting?**  Referrer  Decision Maker (if different)  Other | | | | | | |
| **If Other, please provide details below:** | | | | | | |
| **First Name:** | | | **Last Name:** | | | |
| **Organisation:** | | | | | | |
| **Job Title:** | | | | | | |
| Doctor  Ward Manager  Care Manager  Care Home Manager  Nurse / Health Professional  Administrator  Other (please state) | | | | | | |
| **Address:** | |  | | | | |
| **Postcode:** | | | | | | |
| **Work Tel No:** | | | | **Mobile No:** | | |
| **Email:** | | | | | | |

**Declaration:**

* I would like to instruct an IMCA and am authorised to do so.
* I am providing this information and making this referral in relation to the Mental Capacity Act 2005.
* In accordance with current Data Protection legislation, I agree to the Plymouth Advocacy delivery partners holding personal information (including information on this form).
* I understand the provision of an advocacy service is subject to the client meeting eligibility criteria.

**Please e-mail the completed form to** [info@theadvocacypeople.org.uk](mailto:info@theadvocacypeople.org.uk)

or post to P.O. Box 375, Hastings TN34 9HU

If you have not received confirmation of this referral within 2 working days, or you would like to discuss any aspects of a referral, please call **0330 440 9000**

By requesting advocacy support, you give consent to Plymouth Advocacy sharing information, as required for the purposes of providing the service. For more information on our Privacy Policy, please ask your advocate or go to [www.theadvocacypeople.org.uk/privacy](http://www.theadvocacypeople.org.uk/privacy)

**Confidentiality:**

Communications between you and Plymouth Advocacy are confidential. We will not divulge any information without your permission unless disclosure is required or permitted by law, e.g. where you tell us something which leads us to believe you or someone else may be at risk of serious harm or abuse or committing a serious criminal offence, where there is a court order for disclosure, or where we would be breaking the law by failing to disclose.

All records are held by The Advocacy People in accordance with current Data Protection legislation.