**Independent Mental Capacity Advocate Referral Form**

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| **Client Details** | |
| **Date of Referral:** |  |
| **Name:** |  |
| **Current Address:** |  |
| **Home Address (if different)** |  |
| **Home / Mobile Number(s):** |  |
| **Ward Contact Number(s):** |  |
| **Email:** |  |
| **DOB:** |  |
| **Age** | 18 to 25  26 to 35  36 to 45  46 to 55  56 to 65  66 to 74  75+  Prefer not to say |
| **Communication Requirements:** | British Sign Language  Non - verbal  Spoken English  Gestures / Facial Expressions / Vocalisations  Pictures / Symbols / Makaton  Requires information written down  Prefers Easy Read  Requires an Interpreter  Other – Please describe: |
| **Physical Accessibility Requirements:** | Please describe: |
| **Individuals condition, impairment or disability:** | Mental Health Condition  Physical Disability  Acquired Brain Injury  Learning Disability  Autistic Spectrum Diagnosis  Stroke  Cognitive Impairment  Sensory Impairment  Long term health condition  Dementia  Substance misuse/addiction  Unconsciousness  Neurological Conditions  None  Other - Please describe: |
| **Gender:** | Female  Male Prefer not to say  Prefers to self-describe, please say how:  Is their gender identity different from the one they were assigned at birth?  Yes  No  Prefer not to say |
| **Ethnicity:** | **Asian or Asian British**  Asian British  Bangladeshi  Chinese  Indian  Pakistani  Another Asian background, please describe:  **Black, African, Caribbean, or Black British**  African  Black British  Caribbean  Another Black, African or Caribbean background, please describe:  **Mixed or Multiple ethnic groups**  Asian and White  Black African and White  Another Mixed or Multiple Black Caribbean and White ethnic groups, please describe:  **White**  Gypsy or Irish Traveller  English  Irish  Northern Irish  Scottish  Welsh  Another White background,  Other European  please describe:  **Another ethnic group**  Arab  Another ethnic group, please describe:  Prefer not to say |
| **Sexual Orientation:** | Asexual Bisexual Gay  Heterosexual  Lesbian Pansexual Questioning Prefer to self-describe, please say how:  Prefer not to say |
| **Religion or Belief:** | Buddhist  Christian  Hindu  Jewish  Muslim  Sikh  No religion  Prefer not to say  Another religion or belief, please say which: |

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| **Consent** | | |
| 1. Has the individual consented to the referral? (If **yes**, continue to the next section - Area of Support Required) | **Yes** | **No** |
| 1. If consent has not been given, has this individual been assessed as lacking capacity? | **Yes** | **No** |
| 1. If **Yes** are you giving us instruction in line with the Mental Capacity Act? | **Yes** | **No** |
| What was the date of the capacity assessment? | **Date:** | |
| If you have answered **No** to question 2 & 3, then we are unable to proceed with the referral: please call us on 01332 299 449 Option 2 to discuss this further. | | |

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| **Decision to be made *(Please Only Mark One):*** | |
| Serious Medical Treatment |  |
| Long Term Accommodation Move |  |
| Safeguarding |  |
| Care Review |  |
| Please provide details of the specific decision to be made: | |

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| **Does the person have any family or friends *(Please Only Mark One):*** | |
| Yes, but are not willing/able/appropriate to be consulted about the decision |  |
| No |  |

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| **Eligibility Criteria** | | |
| Does the person lack capacity to make this specific decision currently? | **Yes** | **No** |
| Name and contact details of the person who assessed capacity: |  | |
| Date of the Capacity Assessment **(Mandatory)**: |  | |
| Has the individual been referred to the IMCA service previously? | **Yes** | **No** |

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| **Risk Management** |
| Are there any potential risks for the advocate providing support? or any potential risks for the individual receiving support from an advocate? |

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| **Best Interests Decision Maker Details** | |
| Full Name: |  |
| Job Title: |  |
| Team/Organisation: |  |
| Address: |  |
| Telephone: |  |
| Email: |  |
| Please note this is the person the IMCA will provide their report to. | |

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| **Referrer Details** | |
| Full Name: |  |
| Job Title: |  |
| Team/Organisation: |  |
| Address: |  |
| Telephone: |  |
| Email: |  |
| Relationship to client: |  |
| **By signing this document, you are instructing Disability Direct Advocacy to do this work, and you are authorised by the NHS Body/Local Authority responsible for making this decision.** | |
| Signature: |  |
| Date: |  |

Please send the completed referral form to:

Email: [advocacy@disabilitydirect.com](mailto:advocacy@disabilitydirect.com)

Post: DDA, 20 Royal Scot Road, Pride Park, Derby, DE24 8AJ

If you have any questions or concerns, please give us a call on 01332 299 449 - Option 2