**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 Europeanplease 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

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