|  |
| --- |
| **IMCA Referral Form** |

|  |  |
| --- | --- |
| **Date Received:** |  |
|  |
| **Consent** |
| Has the individual consented to the referral? | **Yes** |  | **No** |  |
| If **Yes**, **Go to Individual Details** |
| If **No**, has this individual been assessed as lacking capacity? | **Yes** |  | **No** |  |
| 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 **No** then we are unable to proceed with the referral: please call the helpline on 01332 228748 |
|  |

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| --- |
| **Individuals Details** |
| Individual Name: |  | Date of Birth: |  |
| Current Address: |  |
| Home Address:(if different) |  |
| Home/mobile telephone numbers  |  |

**How does the individual communicate? Do they have physical access needs?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Spoken English |  | Need Interpreter |  | Gestures/Facial Expression/Vocalisations |  |
| BSL |  | No Obvious Communication |  | Pictures/Symbols/Makaton |  |
| Physical access needs |  | Do not use the telephoner |  | Need information written down |  |
| Prefer Easy Read  |  |  |  |  |  |
| Other: (give details) |  |  |

**Nature of client’s impairment (mark all that apply)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Physical Disability |  | Mental Health Condition |  | Acquired Brain Injury |  | Learning Disability |  |
| Autistic Spectrum Diagnosis |  | Stroke |  | Dementia |  | Cognitive Impairment |  |
| Sensory Impairment |  | Long term health condition |  | Substance misuse/addiction |  | Unconsciousness |  |
| Neurological conditions |  | None |  |  |  |  |  |
| Other: (give details) |  |

**Diversity Monitoring**

We want to ensure that we reach everyone who needs to use our services. The information that you provide below can inform us whether we do and will help us to improve our services.

**What is the gender of the person you are referring**?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Male |  | Female |  | Non-binary |  | Other |  |
| Don’t know/prefer not to say |  |  |

**Is this different from their gender assigned at birth**?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Ye~~s~~ |  | No |  | Don’t know/prefer not to say |  |

**What is their sexual orientation**?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Heterosexual/straight |  | Bisexual |  | Gay man |  |
| Gay woman/lesbian |  | Don’t know/prefer not to say |  | Prefer to self-describe |  |

**What is their ethnic group?**

|  |
| --- |
| **Asian or Asian British** |
| Bangladeshi |  | Pakistani |  |
| Chinese |  | Another Asian background |  |
| Indian |  | Don’t know/prefer not to say |  |
| **Black, Africa, Black British or Caribbean** |
| African |  | Another Black background |  |
| Caribbean |  | Don’t know/prefer not to say |  |
| **Mixed or multiple ethnic groups** |
| Asian and White |  | Another Mixed background |  |
| Black African and White |  | Don’t know/prefer not to say |  |
| Black Caribbean and White |  |  |
| **White** |
| British, English, Northern Irish |  | Another White background |  |
| Irish |  | Scottish |  |
| Irish Traveller or Gypsy |  | Don’t know/prefer not to say |  |
| **Another ethnic group** |
| Arab |  | Another ethnic background |  |
| Don’t know/prefer not to say |  |  |

**What is their religion?**

|  |  |  |  |
| --- | --- | --- | --- |
| No religion |  | Christian (all denominations) |  |
| Buddhist |  | Hindu |  |
| Jewish |  | Muslim |  |
| Sikh |  | Other (please state) |  |
| Don’t know/prefer not to say |  |  |  |

**Please select the Decision to be made:**

Please tick one of:

|  |  |
| --- | --- |
| Serious Medical Treatment |  |
| Long Term Accommodation Move  |  |
| Safeguarding |  |
| Care Review |  |

**Please provide details of the specific decision to be made:**

|  |
| --- |
|  |

**Does the person have any family or friends? Please tick one of:**

|  |  |
| --- | --- |
| Yes, but are not willing/able/appropriate to be consulted about the decision |  |
| No  |  |

**Does the person lack capacity to make this specific decision at this time?**

**Please tick one of:**

|  |  |
| --- | --- |
| 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 |  |

**Are there any potential risks for the advocate providing advocacy support or potential risks for the individual receiving advocacy support?**

|  |
| --- |
|  |

**Contact details of the Referrer and the Best Interests Decision Maker**

|  |  |
| --- | --- |
| **Details of person completing this form** | **Who will make the best interests decision**(this is the person the IMCA will provide their report to) |
| Name: |  | Name: |  |
| Job Title: |  | Job Title: |  |
| Team/Organisation: |  | Team/Organisation: |  |
| Address: |  | Address: |  |
| Telephone: |  | Telephone: |  |
| Email: |  | Email: |  |

I am instructing ONE Advocacy to do this work. I am authorised by the NHS Body/Local Authority responsible for making this decision.

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |  | Date:  |  |
|  |
| Name (please print): |  | Relationship to client:  |  |

Send completed form to:

Online**:** referrals@oneadvocacyderby.org

Postal address: one advocacy, 3rd Floor, Stuart House, Green Lane, Derby, DE1 1RS

Telephone support & triage: 01332 228748

Individuals: OAclients@citizensadvicemidmercia.org.uk

Professionals: referrals@oneadvocacyderby.org

