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| **IMHA Referral Form** |

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| --- | --- |
| **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 |  | | |
| Ward Contact Number(s): |  | | |

**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 individual’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 |  |  |  |

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| **Qualifying patients for IMHA – detained patients (please mark)**  *\*excluding those subject to sections 4, 5(2), 5(4), 135 or 136* | | | | |
| Section Type **\*** Mandatory |  | Date of section: **\*** Mandatory | **\_\_/\_\_/\_\_** | |
| Is the person subject to a Community Treatment Order (CTO) or conditional discharge? | | | |  |
| Is the person subject to guardianship? | | | |  |

|  |  |
| --- | --- |
| **Qualifying patients for IMHA – informal patients (please tick)** | |
| Informal patients who are liable to be detained under the Act |  |
| Informal patients who are discussing the possibility of being given section 57 treatment.  (Treatment which requires consent and a second opinion) |  |
| People under 18 who are being considered for electro-convulsive therapy (ECT) |  |

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| **Please give brief details of reason for IMHA involvement** (continue on separate sheet if necessary) |
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| --- |
| **Please give full details of any important meeting dates or deadlines or such as Mental Health Act Tribunals, Hospital Manager Reviews, CPA review** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Are there any potential risks for the advocate providing advocacy support or potential risks for the individual receiving advocacy support?**   |  | | --- | |  |   **Details of person completing this form** | | |
| Name: |  |
| Job Title: |  |
| Team/Organisation: |  |
| Address: |  |
| Telephone: |  |
| Email: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed:** |  | **Date:** |  |
|  | | | | |
| Name (please print): | | | |

Send completed form to:

Online: [referrals@oneadvocacyderby.org](mailto: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](mailto:OAclients@citizensadvicemidmercia.org.uk)

Professionals: [referrals@oneadvocacyderby.org](mailto:referrals@oneadvocacyderby.org)

A picture containing text, outdoor

Description automatically generated