**IMCA referral form**

**\* = compulsory question**

|  |
| --- |
| **DETAILS OF PERSON BEING REFERRED** |
| **Forename: \*** |  | **Home Address and Post Code: \*\*** |  |
| **Surname: \*** |  |
| **Date of Birth: \*** |  |
| **Contact no:**  |  |
| **Other contact No:**  |  | **Address and Post Code at Time of Referral (if different)** **\*\*** |  |
| **Email:** |  |
| **Can voicemail messages be left?** | **Home**  | **Y/N** | **Mobile:** | **Y/N** |
| **Is this person due to be discharged from hospital?** | **Y/N** |

|  |
| --- |
| **ACCESSIBILITY INFORMATION** |
| **Preferred Language\*** |  |
| **Access Needs and other requirements\*** |  |

|  |
| --- |
| **DEMOGRAPHIC INFORMATION***This information is used for monitoring purposes and to signpost service users to relevant services. Any information given should be determined by the person being referred, given voluntarily, and will be stored confidentially in line with data protection laws.* |
| **Gender:** |  | **Faith or Religion:** |  |
| **Ethnicity:** |  | **Sexual Orientation:** |  |

|  |
| --- |
| **SAFEGUARDING** |
| **Are there any known risks to working with this individual? \*** |  |

**THE DECISION BEING MADE**

There is a statutory duty to instruct an IMCA in change of accommodation or SMT decisions. Please see professional guidance for IMCA and Care Act Advocacy at [www.manchesteradvocacyhub.co.uk](file:///%5C%5CGCSVR1%5Cpublic%5CAdmin%5C2.%20Phone%20Folder%5CReferral%20Forms%5CAdvocacy%5Cwww.manchesteradvocacyhub.co.uk)

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

|  |
| --- |
| **PLEASE INDICATE THE NATURE OF THE DECISION TO BE MADE (please tick one) \*** |
| Serious Medical Treatment (SMT) |[ ]
| Change of Accommodation | [ ]  |
| Safeguarding Adult Review *(Wherein the person you are referring is the alleged perpetrator. Otherwise, please make a Care Act Referral)* |[ ]
| Please provide further details below: |
|  |

**Under the Mental Capacity Act, we must seek instruction from the Decision Maker before processing this referral.**

|  |
| --- |
| **DECISION MAKER (if different from referrer)** |
| **Name:**  | **Organisation:**  |
| **Designation:**  | **Telephone No:**  |
| **E-mail address:**  | **Fax No:**  |

|  |
| --- |
| **OTHER PROFESSIONALS INVOLVED:** |
| **Name:** | **Designation:** | **Telephone No:** |
|  |  |  |
|  |  |  |
|  |  |  |

 |

**QUALIFYING CRITERIA**

**To process this referral, we need confirmation that a time and decision specific capacity assessment has been carried out and details of the outcome.**

|  |
| --- |
| **CAPACITY ASSESSMENT** |
| Has a time and decision specific capacity assessment been carried out **\*** | Yes [ ]  | No [ ]  |
| If YES, what date was the capacity assessment undertaken? **\*** |  |
| Completed by: **\*** |
| Outcome of capacity assessment (Please detail below the ways in which the person being referred lacks capacity remembering that capacity is issue-specific)\*: |
|  |
| **With the exception of safeguarding investigation referrals, an IMCA cannot be appointed if the person has friends or family who are willing and able to act in the persons best interests (as defined in the Mental Capacity Act).** |
| **DOES THE SERVICE USER HAVE ANY KNOWN FAMILY AND FRIENDS? \*** |
| **Yes** [ ]  | **No** [ ]  |
| If you ticked ‘YES’ please explain why the friends or family members are deemed inappropriate to consult by the Decision Maker;  |
|  |

**REFERRER DETAILS\***

*By signing you agree to Gaddum keeping this information stored on a secure electronic case recording system, computer, and paper filing system. You confirm you are providing this information and asking for this referral in the client’s best interests.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Designation:** |  |
| **Organisation:** |  | **Contact No:** |  |
| **E-mail Address:** |  | **Date of referral:** |  |
| **Signature:** |  |

**Please submit this fully completed referral form via one of the following methods:**

|  |  |
| --- | --- |
| **Password protect the file and send to:** | **advocacy@gaddum.org.uk** |
| **Submit via Egress to:** | **advocacy@gaddum.org.uk** |
| **Submit via secure email for NHS Staff:** | **gaddum.centre@nhs.net** |