**IMHA REFERRAL FORM**

**\* = compulsory question**

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| **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) including Ward \*\*** |  |
| **Email:** |  |
| **Can voicemail messages be left?** | **Home**  | **Y/N** | **Mobile:** | **Y/N** |

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

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| **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:** |  |

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| **SAFEGUARDING** |
| **Any Known Risks? \*** |  |

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| **Please mark ‘X’ in one box to confirm how the patient qualifies for the IMHA Service \*** |
| **The patient is detained under a section:***Section 4, 5(2), 5(4), 135 or 136 are not eligible.* | **Date section started: \*** |
|[ ]  s.2 (assessment) |  |
|[ ]  s.3 (treatment) |  |
|[ ]  Any other section *e.g. s.35 (remand for reports), s.36 (remand to hospital) s.47 (Prison transfer) s.48 (Prison transfer on remand / civil prisoner)* |  |
| **The patient is subject to a Guardianship:** |
|[ ]  Section 7 (civil guardianship) |  |
|[ ]  Section 37 or 38 (guardianship via the courts) |  |
| **The patient is a conditionally discharged restricted patient or on a CTO:** |
|[ ]  The patient is a conditionally discharged restricted patient (section 41) |  |
|[ ]  Section 17a (supervised community treatment order) |  |
| **The patient is an informal patient:** |
|[ ]  The patient is an informal patient but section 57 medical treatment is being considered |
|[ ]  The patient is an informal patient and under 18 and being considered for ECT or any other section 58A treatment |

**Does the person have capacity to consent to the referral? \***

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| Yes [ ]  | No [ ]  |

**If yes, has consent been obtained?**

|  |  |
| --- | --- |
| Yes [ ]  | No [ ]  |

**Please provide details of any forthcoming meeting dates and any other information\***

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**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.*

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| **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:**

|  |  |
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| **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** |