**Independent Mental Health Advocacy IMHA**

Please complete this form in full and return it to: advocacy@weareecs.co.uk or return by post to: **Healthwatch Halton Advocacy Hub, Office H, A.R.T Centre, Tanhouse Lane, Widnes, WA8 0RR**

If you need support to complete this form, please contact us on **0151 347 8183**

**Section A: Patient Information**

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| --- | --- |
| Name:  |  |
| Date of Birth: |  |
| Gender: |  |
| Permanent Address:  |  | Postcode:  |
| Please describe the issue/ specific reasons why you are requesting IMHA support:  |
| Are there deadlines/ important dates relevant to the issue/s? If yes, please specify: |

Where is the Patient Currently Detained/ Residing?

|  |  |
| --- | --- |
| Ward:  |  |
| Hospital/ Care Home:  |  |
| Address:  |  |
| Postcode:  |  |
| Telephone number:  |  |
| Email address:  |  |
| Does the patient have any communication needs? (please specify)  |  |

Section B: How does the Patient Qualify for IMHA? (please tick and provide relevant date)

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| The patient is detained under section 2 of the Mental Health Act 1983:  |  | Section start date:  |
| The patient is detained under section 3 of the Mental Health Act 1983:  |  | Section start date: |
| The patient is detained under part 3 of the Mental Health Act 1983 (‘forensic/ ‘forensic restricted;’ patients):  |  | Section start date:  |
| The patient is subject to a Community Treatment Order (CTO) under the Mental Health Act 1983: |  | Order start date:  |
| The patient is subject to a Guardianship Order under the Mental Health Act 1983:  |  | Order start date:  |
| The patient is a voluntary/ ‘informal’ patient who may be given Section 57 treatment under the mental Health Act 1983:  |  | Please provide details:  |

**For Professionals**

|  |  |
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| Has the patient provided consent for this referral to be made?  |  |
| Has the patient been formally assessed or is it otherwise believed that they lack the mental capacity to consent to the referral being made?  |  |
| Has the patient been formally assessed or is it otherwise believed that they lack mental capacity regarding the relevant issue/s?  |  |
| Has the eligibility checklist been completed (For people not sectioned under the Mental Health Act)?  |  |

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| Please provide details of any risks or behaviours the Advocate needs to be aware of when dealing with the referral:  |
| Signature of referrer: | Date:  |

**For internal use only**

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| Date referral received:  | Date first contacted:  |
| Date of appointment:  | Time of appointment: |
| Allocated advocate name: |