

Independent Mental Capacity Advocacy (IMCA) Referral Form

Please complete this form in full and return it to: advocacy@ecstaffs.co.uk or return by post to: **Healthwatch Halton Advocacy HUB, Suite 5, Foundry House, Widnes Business Park, Waterside Lane, Widnes WA8 8GT**

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

Section A: About the person

| | | |
|---|-----|----|
| Name of person: | | |
| Date of Birth: | | |
| Current place of residence: | | |
| NHS Number/Social Care Number: | | |
| Telephone number: | | |
| Equal Opportunities form completed? Please tick | Yes | No |

Section B: What is the Best Interest Decision? (Please tick)

| | |
|---|--|
| Serious Medical Treatment | |
| Long Term Accommodation | |
| For Long Term Accommodation, what is the projected discharge date? (DD/MM/YY) | |
| Adult Protection | |
| Care Review | |
| Please describe the decision: | |
| Date decision needs to be made by: | |
| Any other deadlines/ meeting dates (please specify including dates): | |

Section C: Capacity Assessment

| | |
|---|--|
| Has a capacity assessment been completed? | |
| Name of Assessor: | |
| Designation (e.g. Social Worker): | |
| Date of Assessment: | |

Section D: Family and Friends

| | | | | |
|---|-----|--------------------------|----|--------------------------|
| Does the referred person have a family? Please tick | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Does the referred person have any friends? Please tick | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Are the person's family appropriate to be involved in the best interest decision? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| If no, what is the reason the family are not involved? | | | | |
| | | | | |

Section E: Risk and Support Needs

| |
|--|
| <p>Risks: Please detail any information relevant to ensuring the safety of the person or of the advocate (or both):</p> |
| <p>Support Needs: Please detail any support needs the advocate will need to provide support e.g. Language or preferred communication methods:</p> |
| <p>Safeguarding: Please detail any existing safeguarding concerns that the advocate should be aware of:</p> |

Section F: Key People

| | | |
|--|---|---|
| | Professional making the best interest decision: | Referred (if different from decision maker) |
| Print name | | |
| Position | | |
| Organisation | | |
| Telephone No | | |
| Mobile No | | |
| Email | | |
| Fax No | | |
| Pager | | |
| Involved professionals (not listed above) and contact details: | | |
| Is the referred person aware of the advocacy referral? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Signature (Referrer) | | Date: |
| Signature (Decision Maker) | | Date: |

Please complete this form in full and return it to: advocacy@ecstaffs.co.uk or return by post to: **Healthwatch Halton Advocacy HUB, Suite 5, Foundry House, Widnes Business Park, Waterside Lane, Widnes WA8 8GT**

For internal use only

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

EQUAL OPPORTUNITIES- PLEASE COMPLETE

Do you consider the person you are referring as:

- Male
 Female
 Transgender
 Rather not say

How would you describe their ethnic origin or background?

| | | |
|--|---|--|
| <p>Asian</p> <p> <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any other Asian background (please write in) </p> | <p>Black</p> <p> <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other Black Background (please write in) </p> | <p>Chinese or other ethnic group</p> <p> <input type="checkbox"/> Chinese <input type="checkbox"/> Any other Ethnic group (please write in) </p> |
| <p>Mixed</p> <p> <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Asian <input type="checkbox"/> Any other Mixed background (please write in) </p> | <p>White</p> <p> <input type="checkbox"/> English <input type="checkbox"/> Irish <input type="checkbox"/> Scottish <input type="checkbox"/> Welsh <input type="checkbox"/> Any other White background (please write in) </p> | <p><input type="checkbox"/> Rather not say</p> |

Do you consider them to have the following?

| | |
|---|--|
| Physical/mobility impairment, such as a difficulty using your arms or mobility issues which require you to use a wheelchair or crutches | |
| Visual impairment, such as being blind or having a serious visual impairment | |
| Hearing impairment, such as being deaf or having a serious hearing impairment | |
| Mental health condition, such as depression or schizophrenia | |
| Learning disability/difficulty, such as Down's syndrome or dyslexia or a cognitive impairment such as autistic spectrum disorder | |
| Long-standing illness or health condition, such as cancer, HIV, diabetes, chronic heart disease or epilepsy | |
| Other (Please specify below) | |

How would you describe their sexuality?

- | | | |
|-----------------------------------|---|---|
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> Homosexual/Gay | <input type="checkbox"/> Rather not say |
| <input type="checkbox"/> Lesbian | <input type="checkbox"/> Heterosexual/ straight | |

How would you describe their religious beliefs?

- | | | | |
|--|---------------------------------|-----------------------------------|---|
| <input type="checkbox"/> No Religion | <input type="checkbox"/> Baha'i | <input type="checkbox"/> Buddhist | <input type="checkbox"/> Christian |
| <input type="checkbox"/> Hindu | <input type="checkbox"/> Jain | <input type="checkbox"/> Jewish | <input type="checkbox"/> Muslim |
| <input type="checkbox"/> Sikh | | | <input type="checkbox"/> Rather not say |
| <input type="checkbox"/> Other (please write in) _____ | | | |

Referral Receipt

Healthwatch Halton Advocacy HUB will confirm receipt of all IMCA referrals within 24 hours. If you have not received this confirmation, please contact us on 0151 347 8183 or advocacy@ecstaffs.co.uk