

### Independent Mental Health Advocacy IMHA

Please complete this form in full and return it to: [advocacy@ecstaffs.co.uk](mailto: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: Patient Information

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)**

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**

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

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**

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