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| A close up of a logo  Description automatically generated | **Advocacy Referral Form**  **Independent Mental Capacity Advocacy (IMCA)** |

This form is for our [**Independent Mental Capacity Advocacy (IMCA)**](https://advonet.org.uk/services/independent-mental-capacity-advocacy-imca/) service. You must complete all relevant questions to ensure that your advocacy referral is processed. Any incomplete information will result in a delay in your referral being processed.

Once completed, please email this referral form to [**office@advonet.org.uk**](mailto:office@advonet.org.uk). Please note that sensitive data is emailed to us at your own risk. If you would like to give information over the phone or discuss a secure way to make an advocacy referral, please call our First Contact Team on **0113 244 0606**.

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| Date of Referral (DD/MM/YYYY) | 23/10/2023 |
| Your Name |  |
| Your Email Address |  |
| How did you hear about this service? | Choose an item. |

**Eligibility for an Independent Mental Capacity Advocate**

Eligibility is set out in Chapter 10 of the Mental Capacity Act Code of Practice as follows. Please select to confirm eligibility.

NB To be completed by a medical or social care professional only. If you need assistance, please call The Advonet Group on **0113 244 0606**.

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| Decision | Choose an item. |
| Circumstances | Person lacks capacity to make this decision \*  There is no one appropriate available to support the person other than paid staff |

\*Someone lacks capacity if they have an impairment of the mind or the brain AND (with regard to the specific decision to be made) are unable to:

* Understand information
* Retain information
* Weigh up pros and cons
* Communicate a decision

A person may have capacity but have substantial difficulty. Please see our [Care Act Advocacy Referral Form](https://advonet.org.uk/referrals/care-act-advocacy-referral-form/) if there is a Social Care process for someone who has substantial difficulty.

Note – to progress to the next section of this form, you must choose one ‘decision’ and click on both ‘circumstances’.

**Part 1: What is the main reason for this referral?**

If the reason for referral is either a Care Review or Safeguarding, please make a [Care Act Advocacy Referral](https://advonet.org.uk/referrals/care-act-advocacy-referral-form/).

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| Reason for Referral | Choose an item. |
| Has a capacity assessment been carried out for this specific decision? | Choose an item. |
| If yes, does the person lack capacity for this decision? | Choose an item. |
| Date of capacity assessment (DD/MM/YYYY) |  |
| Please confirm that there are **no** other people (other than paid people) who are appropriate to consult with?  For guidance about who is appropriate to consult, [click here](https://advonet.org.uk/referrals/imca-appropriate-to-consult-guidance/). | Choose an item. |
| Names and details of key contacts |  |

**Part 2: Change of Accommodation**

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| Brief reason for referral and options to be considered |  |
| Name of the Decision Maker (if not the referrer) |  |
| Email and phone number |  |
| - Or - | |
| Decision Maker has not been identified | |
| Please explain why in this box |  |

**Part 3: Serious Medical Treatment**

(Where the treatment proposed has finely balanced benefits and burdens, or there is a finely balanced choice of treatments, or what is proposed is likely to have serious consequences for the patient).

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| Please indicate the Serious Medical Treatment you are considering providing, withholding or stopping |  |
| Please tick any of the boxes on the right that apply to the patient. | Treatment involves a general anaesthetic  The person is currently an inpatient |
| Hospital: |  |
| Ward / Direct Telephone Number: |  |
| Is the person currently in the Leeds City Council area? (Somewhere that pays Council Tax to Leeds)\*  \*If this is an outpatient who is being referred to a hospital outside of Leeds but they are in Leeds at the time of the referral we would accept this – tick the box | Yes |
| Name of the Decision Maker: |  |
| Email and phone number of the Decision Maker: |  |
| - Or - | |
| Decision Maker has not been identified | |
| Please explain why in this box |  |

**Part 4: Relevant Person’s Details (the person who needs advocacy)**

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| Name |  |
| Current Address |  |
| Postcode |  |
| Home Address (where the person usually lives) |  |
| Preferred contact method | Choose an item. |
| Contact number |  |
| Can we leave a message? | Choose an item. |
| Is the relevant person aware this referral is being made? | Choose an item. |

**Part 5: Referrer Details: Tell us a bit more about yourself**

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| Job Title |  |
| Employer | Choose an item. |
| Phone number: |  |
| Place of work (including address) |  |

**Part 6: Risk Issues**

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| Are there any current Risk Issues we need to be aware of? | Choose an item. |
| Please write any details of Risk Issues in the box to the right: |  |

**Part 7: Other relevant information about the person requiring advocacy**

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| If you / the client has any support needs e.g. communication, please write them down in the box on the right. |  |
| What is the person’s first language? |  |
| Are there any additional communication or other needs not already mentioned e.g. needing advance notice of meeting dates/times? |  |

The following information is collected to help us create equal opportunities for individual’s resident within our local communities. We use this information anonymously to identify if the diversity of the people accessing our services fully reflects the communities we serve. If you prefer not to answer, please select that option.

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| Your Date of Birth – we ask for this information as some of our services are for specific ages (DD/MM/YYYY) |  |
| Gender | Choose an item. |
| Gender – other: Please tell us |  |
| Is their gender the one they were assigned at birth? | Choose an item. |
| Ethnicity | Choose an item. |
| Ethnicity – other: Please tell us |  |
| Religion | Choose an item. |
| Religion – other: Please tell us |  |
| Sexuality | Choose an item. |
| Sexuality – other: Please tell us |  |
| Disability – for monitoring and equal opportunity purposes, please let us know if the person has any of the following disabilities/impairments by ticking the relevant boxes | Acquired Brain Injury  Autism Spectrum Condition  Blind / Partially Sighted  Cognitive Impairment  Deaf / Partial Hearing  Dementia  Learning Disability  Long-Term Health Condition  Mental Health Needs  Older Person (Frailty)  Physical Condition / Illness |
| Is the client disabled in any other way not listed above? If so, please write in this box. |  |

## **Glossary of Terms**

*Non-binary* refers to individuals who don’t see themselves as either male or female. Individuals identifying as non-binary may ask you to use gender neutral pronouns such as they/their rather than he/she. Please do not ask non-binary individuals the sex or gender assigned to them at birth as this is irrelevant.

*Trans* male/female refers to individuals who are transitioning to the gender they identify with.

*Pansexual* refers to individuals who are romantically, emotionally, sexually attracted to people regardless of their sex and gender identity.