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

This form is for our [**Independent Mental Health Advocacy (IMHA)**](https://advonet.org.uk/services/independent-mental-health-advocacy-imha/) 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**. 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. |

**Part 1: Section Details**

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| What section is the client under? | Choose an item. |
| If someone is in a Crisis Assessment Unit, they might also be eligible for an IMHA |
| Other: Please state |  |
| Section start date (DD/MM/YYYY) |  |
| Section expiry date (DD/MM/YYYY) |  |
| Name of Responsible Clinician (RC): |  |
| Contact details for RC (please provide direct contact details i.e. email address, phone number, postal address of workplace) |  |
| Date rights under Mental Health Act last read to client (DD/MM/YYYY): |  |

**Part 2: Purpose of Referral**

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| Is the referral by, or upon request of, the client? | Choose an item. |
| If "No", what is the advocacy need? |  |

**Part 3: Details of Nearest Relative or any other relevant person e.g. close friend**

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| Details of nearest relative or any other relevant person (name, phone number, email address) |  |

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

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| Name |  |
| Current Address/ward/unit  |  |
| Postcode |  |
| Preferred contact method | Choose an item. |
| Enter your contact details here, e.g. email, mobile number or the contact details of the person who is helping you. (If you give us their contact details, we will take this as consent that we can contact them to discuss your issue) |  |
| Current phone number |  |
| Can we leave a message? | Choose an item. |

**Part 5: 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 6: 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 your/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 your gender the one you 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 you/the client have 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 [ ]  |
| Are you/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.