**STATUTORY IMCA REFERRAL**

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| **Guidance on completing this form**The purpose of the IMCA service is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about these decisions, or about care reviews or Adult Protection proceedings.The Mental Capacity Act 2005 (MCA) says everyone has the right to make their own decisions and must be given all practicable help to do so, before they are deemed as lacking capacity. The person’s capacity must be assessed in relation to the decision to be made. Generic assessments of capacity are not sufficient.**The IMCA service safeguards the rights of people aged 16 years and over who:*** **lack capacity to make a specified decision at the time it needs to be made; and**
* **have nobody else who is willing and able to represent them or be consulted in the process of working out their best interests, other than paid staff**

NHS and Local Authority Decision Makers need to determine if there are family, or friends, who are willing and able to be consulted about the proposed decision. If not, an IMCA will work with, and support people, who lack capacity, and represent their views to those who are considering their best interests in accordance with the MCA.If a decision needs to be taken about a Care Review or Safeguarding case, there is now a statutory duty to refer under the Care Act 2014, and an ICAA referral should be made for an Independent Care Act Advocate. |

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| ***NB. Please ensure all parts of the form relating to the relevant decision/issue are completed and IMCA criteria is met, by checking relevant tick boxes, and providing further information in the free-text boxes available. Failure to complete all relevant parts of the form may result in delaying the appointment of an IMCA.*** |

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| Date of referral |  |
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| **Professional referrer’s details** |
| First name |  | Surname |  |
| Organisation |  | Job Title |  |
| Telephone |  | Mobile |  |
| Email |  |

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| **Details of person requiring an IMCA** |
| **Client information** |  |
| Full name (including title) |  |
| Date of birth |  |
| Home address |  |
| Post Code |   |
| Address of current location (if different from home address) |  |
| Post Code  |   |
| Telephone number |  |
| Mobile number |  |
| Email |  |

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| **Service Group** |
| Adult 18-65 in the community  |  | Adult 18-65 in hospital |  |
| Older person 65+ in the community |  | Older person 65+ in hospital |  |
| Carer |  | Vulnerable person |  |
| Other (please specify) |  |

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| **IMCA client current location details** |
| Own home |  | Own home with support |  |
| Supported living |  | Acute psychiatric unit |  |
| Dementia ward |  | Care/Nursing home |  |
| Prison |  | Forensic secure unit |  |
| Hospital |  | Other institution |  |

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| **Preferred method of contact** |
| Telephone |  | Mobile |  |
| Text |  | Email |  |
| Post |  | Any |  |
| Cannot be contacted directly |  |

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| **Client’s primary communication method** |
| Spoken English |  | British Sign Language (BSL) |  |
| Other spoken language (please specify and also whether English is spoken) |  |  |
| Words/Pictures/Makaton |  | Gestures/Facial expressions/Vocalisations |  |
| Other (please specify) |  |  |
| No obvious means of communication |  | Not known |  |

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| **Does the client have a military connection?** |
| Yes, serving |  | Yes, Veteran |  |
| Yes, carer relationship |  | No |  |
| Not known |  | Prefers not to say |  |

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| **Does the client consider themselves to have a disability?** |
| Yes |  | No |  |
| Don’t know |  | Prefers not to say |  |

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| **What type(s) of disability or impairment does the client have? (select all that apply)** |
| Mental health problem |  | Physical disability |  |
| Acquired brain injury |  | Serious physical illness |  |
| Sensory (hearing) |  | Sensory (sight) |  |
| Learning disability |  | Dementia/Alzheimer’s |  |
| Asperger’s/Autism Spectrum Condition |  | Cognitive impairment |  |
| Unconsciousness |  | Other (please specify below) |  |
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| **IMCA referral details** |
| Has the person been assessed, to lack capacity to make a particular decision? | Yes |  | No |  |
| Is a decision being made about long term care and health moves (more than 28 days in hospital/8 weeks in a care home)? | Yes |  | No |  |
| Is the person facing a decision about serious medical treatment? | Yes |  | No |  |
| Are there decisions relating to Adult Protection proceedings? | Yes |  | No |  |
| Is there a care/accommodation review where it felt that the person would benefit from IMCA? | Yes |  | No |  |
| Are there any family and friends **OR** is there anyone (other than paid workers) who are considered willing and appropriate to be consulted about the decision? | Yes |  | No |  |
| **(N.B. this does not apply for Adult Protection proceedings – people can have family and still be eligible)**If YES, briefly describe any concerns about their involvement: |  |
| Is there an Advance Directive, or any other form of record of the client’s wishes? | Yes |  | No |  |
| If YES, please provide details: |  |
| Is this a first referral? | Yes |  | No |  |
| Please provide details of any known risks the Advocate should be aware of. If you are not aware of any risks, please write “No known risks”. |

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| **Details of decision to be made (check ONE box only)** |
| Serious medical treatment |  | Change of accommodation |  |
| Care review |  | Adult Protection Proceedings |  |
| Please provide details: |
| Date the decision needs to be made by: |
| Details and dates of any meetings already arranged: |
| Please summarise the steps taken to assess the lack of capacity (if known) \*: |

\*Date of assessment; who carried out the assessment; where are the notes held? This information is not essential at referral stage.

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| **Details of the person(s) relevant to the referral** |
| Is the referrer the decision maker? | Yes |  | No |  |
| If NO, please provide details: *(if YES, go to the Declaration)* |

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| **Decision maker’s details, if different from the referrer** |
| First name |  | Surname |  |
| Organisation |  | Job Title |  |
| Telephone |  | Mobile |  |
| Email |  |
| Is the decision maker aware of this referral? | Yes |  | No |  |

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| **Declaration** |
| * I would like to instruct an IMCA and am authorised to do so.
* I am providing this information and making this referral in relation to the Mental Capacity Act 2005.
* In accordance with current Data Protection legislation, I agree to the Advocacy HUB’s delivery partners holding personal information (including information on this form).
* I understand the provision of an advocacy service is subject to the client meeting eligibility criteria.
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| **Who can make arrangements for initial client meeting?** |
| Referrer |  | Decision maker (if different) |  | Other |  |
| If Other, please complete the boxes below |
| First name |  | Surname |  |
| Organisation |  | Job Title |  |
| Telephone |  | Mobile |  |
| Email |  |

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| **Monitoring Information** |
| **Ethnicity** |
| **Asian** |  | **Black** |  | **Mixed** |  | **White** |  |  |  |
| British |  | British |  | British |  | British |  | Other |  |
| Bangladeshi |  | African |  | Asian/White |  | Irish |  | Declined |  |
| Chinese |  | Caribbean |  | Black African/White |  | Other |  | Unknown |  |
| Indian |  | Other |  | Black Caribbean/White |  |  |  |  |  |
| Pakistani |  |  |  | Other |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |

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| **Gender** |  | **Sexual Orientation** |  | **Religion** |  |
| Female |  | Bisexual |  | Buddhist |  |
| Male |  | Gay Male |  | Christian |  |
| Intersex |  | Heterosexual |  | Hindu |  |
| Transgender |  | Lesbian |  | Jewish |  |
|  |  | Declined |  | Muslim |  |
|  |  | Not known |  | Sikh |  |
|  |  |  |  | Other |  |
|  |  |  |  | No religion |  |
|  |  |  |  | Declined |  |
|  |  |  |  | Not known |  |

Please email the completed form to: advocacy@southessexadvocacy.org

Or post to: Southend Advocacy Hub

 Unit 2, 225-235 West Road

 Westcliff-on-Sea

 Essex SS0 9DE