**Independent Mental Health (IMHA) and Informal Inpatient REFERRAL**

|  |
| --- |
| **This form can be used by professionals, carers or nearest relatives to refer both Qualifying IMHA Patients and Informal Patients. Patients may also refer themselves directly. In the first instance, talk to the patient and provide them with an opportunity to decide for themselves whether to request help from an IMHA.**  |

**Please complete as many of the boxes as possible to ensure there are no delays to the referral**

|  |  |
| --- | --- |
| Date of referral |  |
|  |  |  |
| **Referrer’s details** |
| Is this a self-referral?  | YES |  | NO |  | If YES, go to details of person requiring IMHA |
| First name |  | Surname |  |
| Organisation |  | Job Title |  |
| Telephone |  | Mobile |  |
| Email |  |

|  |
| --- |
| **Details of person requiring an IMHA** |
| **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 |  |
| National Insurance Number |  |
| NHS number |  |
| Local Authority Number |  |

|  |
| --- |
| **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) |  |

|  |
| --- |
| **IMHA client current location details** |
| Own home |  | Own home with support |  |
| Supported living |  | Acute psychiatric unit |  |
| Dementia ward |  | Care/Nursing home |  |
| Prison |  | Forensic secure unit |  |
| Homeless |  | No fixed abode |  |
| Hospital |  | Other institution |  |
| Ward name (if in hospital):   |

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

|  |
| --- |
| **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 |  |

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

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

|  |
| --- |
| **What type(s) of disability or impairment does the client have? (select all that apply)** |
| Mental health problem |  | Mental Health Diagnosis (please specify) |  |
| 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) |  |
| Physical Disability |  | Physical Disability Diagnosis: (please specify) |  |

|  |
| --- |
| **IMHA referral details** |
| **Qualifying Patients:** This includes detained patients (excluding those subject to sections 4, 5(2). 5(4), 135 and 136) even if they are on leave or conditionally discharged. This also includes patients on 17A Community Treatment Orders, s.7 Guardianship and informal patients under 18 who are being considered for ECT (for full eligibility, see Chapter 6 of the Mental Health Act1983, Code of Practice). Patients with capacity must either consent to the referral, **OR,** the Responsible Clinician, AMHP, or Nearest Relative believes that the patient might benefit from IMHA support but are unable or unlikely (for whatever reason) to request this for themselves. All patients who lack the capacity to decide whether or not to obtain help from an IMHA, must be referred to the service.  |
| To which section of the MHA is the patient subject (if known)?  |   |
| Date of the section:  |   |
| Is patient subject to any further (i) or (ii) section of the MHA (if known)?  |   |
| Please provide detailed information of the patient’s diagnosis: |  |

|  |
| --- |
| **Informal Inpatients:** Although informal inpatients and those detained on short term/emergency sections do not have a legal right to an IMHA, an advocate may be able to provide advocacy on an informal basis, subject to availability. |
| Is the patient subject to Section 117 Aftercare?  | YES |  | NO |  | Don’t know |  |
| Has the patient consented to this referral?  | YES |  | NO |  |

|  |
| --- |
| **Name of responsible Clinician/Consultant Psychiatrist** |
|  |

|  |
| --- |
| **Date of detention (if applicable)** |
|  |

|  |
| --- |
| **What is the issue/situation requiring an advocate?**  |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Is the patient subject to seclusion?** | YES |  | NO |  |

|  |
| --- |
| **Please provide details of any deadlines or important meeting dates** |
|  |
| **Are there any risk factors of which the advocate should be aware? If you are not aware of any risks, please write “No known risks”** |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Does the patient have capacity to request/instruct an advocate?** | YES |  | NO |  |

|  |
| --- |
| **Permission to share** |
| Can an advocate be contacted in the event of discharge into Guardianship or Community Treatment Order? | YES |  | NO |  |

|  |
| --- |
| **Declaration** |
| * I declare that I wish to instruct an IMHA
* I am providing this information and making this referral in relation to the Mental Health Act 1983
* In accordance with current Data Protection legislation, I agree to Southend Advocacy Hub partners holding personal information (including information on this form)
* I understand the provision of an advocacy service is subject to the patient meeting eligibility criteria
 |
| **Signature of referrer** |
|  |

|  |
| --- |
| **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 |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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