

## Independent Mental Capacity Advocate (IMCA) Referral Form

Referral date ..... Received date .....

### Making an appropriate referral

If you follow this guidance sheet it will confirm you are making an appropriate referral.

Please tick Yes or No for the following statements:

Statement	Yes	No
Does the client have a specific condition affecting their ability to make decisions? (E.g. Learning Disability, Mental Health, Acquired brain injury)		
Has the client been assessed as lacking capacity to make this particular decision*?		
Is the client 16 years of age or older?		
Are there any other family members or unpaid persons willing or appropriate to consult in relation to this decision? (with the exception of a safeguarding issue)		
Will the person making the decision, be completing and signing the final page of this form showing they have authorised IMCA involvement?		

\*Decision requiring the involvement of an IMCA should be about one of the following (please tick):

- Serious medical treatment:
- A change of accommodation
- Safeguarding Adult proceedings for someone lacking capacity (The person may have family and still be eligible for IMCA in this instance)
- A care review in relation to accommodation where it is felt that the person would benefit from IMCA

### Referrer Details

Referrer's Name			
Referrer's Job Title			
Is the referrer also the authorised decision maker? (please circle)	Yes	No	
<i>If YES please skip rest of this section and go to the decision maker's confirmation section.</i>			
<i>If NO, please complete the Referrer's address details below <b>and</b> ask the decision maker to complete their confirmation section overleaf.</i>			
Address			
Contact Number			
Email Address			

**IMPORTANT: THE NEXT TWO SECTIONS (regarding the Decision Maker) MUST BE COMPLETED** Adapt NE cannot pick up a referral until we have received confirmation of the following:

Decision Maker's Name:	
Job title:	
Address:	
Phone / email:	
Date:	

<b><u>Decision Maker's confirmation:</u></b>	<b>TICK TO CONFIRM</b>
I confirm that for this issue I am the Decision Maker.	
I confirm that I deem this person to be un-befriended, with no one appropriate to consult regarding this decision. ( <i>With the exception of a safeguarding issue</i> )	
I confirm the person being referred has been deemed to lack capacity to make <u>this decision</u> .	
I confirm that a capacity assessment for this decision was done.  Please state the date of the assessment .....	
<b>Please forward a copy of the assessment with this referral.</b>	

**Client Details**

Client name and title		Mr /Mrs/ Miss/Ms
Client current address		
Client current contact number		
Client permanent address if different		
Client date of birth		

Client Ethnic Background			
White British		White Irish	White Gypsy / Irish Traveller
Other White background		Mixed / Multiple Ethnic Groups: White & Black Caribbean	Mixed / Multiple Ethnic Groups: White & Asian
Mixed / Multiple Ethnic Groups: White & Black African		Mixed / Multiple Ethnic Groups: other	Asian / Asian British: Indian
Asian / Asian British: Pakistani		Asian / Asian British: Bangladeshi	Asian / Asian British: Chinese
Asian / Asian British: other		Black / African / Caribbean / Black British: African	Black / African / Caribbean / Black British: Caribbean
Black / African / Caribbean / Black British: other		Other Ethnic Group: Arab	Other Ethnic Group: other
Any identified religious, cultural or spiritual needs?			

**Does the client have any of the following?**

	Please tick	Please specify
Mental health condition		
Physical health condition or disability		
Learning disability		
Combination		
Special communication needs		
Other specific needs		

**Please tell us about anything else we should know to make sure the client and the Advocate remain safe.**

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**Reason for Referral – tick one only**

Serious Medical Treatment	
Change of Accommodation	
Care Review	
‘Safeguarding Adults’ for person who lacks capacity	

Please give details of the decision to be made that requires IMCA involvement:

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**Significant Dates**

Item	Date (dd/mm/yy)
When do you need the IMCA's report by?	
When does the decision need to be made by?	
Please give details of any impending meetings or deadlines (including date, type of meeting and location if known)	

Are any family, friends or a named person able to help with decision?

YES

NO

Please give details of family members involved:

Name	
Relationship to client	

If no, please give brief details of why they are not involved:

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**Contact details of any other professionals involved:**

	Person 1	Person 2
Name		
Job Title		
Organisation		
Relationship to client		
Phone Number		

**Because of the Data Protection Act, a signature is required to say that you agree to the Northumberland Independent Advocacy service holding personal information, (including this form), on a secure electronic case management system, a computer, and in a paper filing system. It is the policy of the Adapt (North East) Advocacy service that all personal data will be held in accordance with the principles and requirements of the Data Protection and other relevant legislation, and that procedures will be put in place to ensure fair processing of data relating to individuals. Northumberland Independent Advocacy service is a free and confidential service. You can request further information on our confidentiality policy by contacting our main office. Please find contact details below.**

*The referrer: I agree to Adapt (North East) keeping this information stored on a secure electronic case recording system, computer, and paper filing system. I am providing this information and asking for this referral in the client's best interest.*

\_\_\_\_\_  
REFERRER SIGNATURE

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
DATE

**PLEASE RETURN THIS FORM TO:**

**Fax: 01434 605251**

Northumberland Independent Advocacy Service, Adapt (North East),  
Burn Lane, Hexham, Northumberland, NE46 3HN

**Tel: 01434 600599**

