

## INDEPENDENT MENTAL HEALTH ADVOCACY (IMHA) REFERRAL FORM

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| ***For Information and advice on how to complete this form please phone the Devon Advocacy Consortium on 01392 822377.***  ***Failure to complete all relevant parts of this form will result in delayed allocation of this referral.***  ***The referral form should be emailed to*** [***devonadvocacy@livingoptions.org***](mailto:devonadvocacy@livingoptions.org) |

### DETAILS OF THE PERSON BEING REFERRED

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | D.O.B |  |
| Current Address  (if the person is currently staying in a hospital ward/ care home/ prison etc. please indicate which one) |  |  |  |
| Gender |  |
| Postcode |  | Tel |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client currently living in | Own home |  | Care home |  | Hospital |  | Supported living |  | Prison |  | Uncertain |  | Other (specify) |  |

**REFERRAL REASON**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Detained or liable to be detained under the Act (excluding emergency sections)? | Yes |  | No |  |
| Subject to Community Treatment Order or conditionally discharged? | Yes |  | No |  |
| Subject to Guardianship? | Yes |  | No |  |
| Discussing the possibility of section 57 treatment? | Yes |  | No |  |
| Under 18 and considered for electro-convulsive therapy? | Yes |  | No |  |
| ***Please note: If you have ticked no for all, the person is not eligible for an IMHA*** | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Details of the reason for referral | | | | | |  | | | |
| Dates & times of any planned meetings | | | | | |  | | | |
| Type of restriction / section | | | | | |  | | | |
| Date of restriction / section | | | | | |  | | | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | Is the person aware of this referral? | Yes |  | No |  | | Does the person have capacity to instruct an advocate to act on their behalf? | Yes |  | No |  | | If the person cannot instruct an advocate, please confirm that a professional involved in their care has assessed their mental capacity regarding their ability to instruct. | Yes |  | No |  | | **Please note: *if the person does not have the capacity to instruct, we may be able to offer non instructed advocacy. However, this may not be possible if a mental capacity assessment has not been completed.*** | | | | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | Is the person a danger to themselves or others? | Yes |  | No |  | | **If yes, please give details:** | | | | | | | | | | | | | | | |
| **Disability** | | | | | | | | |
| Acquired Brain Injury |  | Autistic Spectrum Condition |  | Cognitive impairment | |  | Dementia |  |
| Learning Disability |  | Mental Health problems |  | Serious Physical Illness | |  | Combination |  |
| Unconsciousness |  | Other  (please state) |  | | | | | |

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| --- | --- | --- | --- | --- | --- |
| **What is the primary communication method?** (tick only one box – the most appropriate) | | | | | |
| English |  | Other spoken language |  | Gestures/vocalizations/facial expressions |  | |
| Sign language (e.g. BSL) |  | Words/Pictures/Makaton |  | No obvious means of communication |  | |
| Other (please state) |  | | | | |

**REFERRER**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Name of Organisation  (if applicable) |  |
| Relationship to client  (eg. Professional role, family relationship or self-referral) |  | Tel |  |
| Address |  | Mobile |  |
| Email |  |

**CLIENT MONITORING INFORMATION**

**We are required to request the following data to ensure that our service is fair and treats our users equally. This information is separate to your referral for advocacy and has no impact on the service that we will provide.**

**The following questions are optional.**

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| --- | --- | --- | --- | --- |
| Is the gender the client identifies with the same as their sex registered at birth? | Yes |  | No |  |

**Ethnic Origin:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **White:** |  | **Mixed:** |  | **Asian or Asian British:** |  | **Black or Black British:** |  | **Other** |  |
| British |  | White & Black Caribbean |  | Indian |  | Black Caribbean |  | Other Ethnic Group (please specify) |  |
| Irish |  | White & Black African |  | Pakistani |  | Black African |  | Not Established |  |
| Other White (please specify) |  | White & Asian |  | Bangladeshi |  | Other Black (please specify) |  |  |  |
|  |  | Other Mixed  (please specify) |  | Chinese |  |  |  |  |  |
|  |  |  |  | Other Asian (please specify) |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is the client married or in a civil partnership? | Yes |  | No |  |

|  |  |
| --- | --- |
| How does the client describe their sexual orientation? |  |

|  |  |
| --- | --- |
| What religion is the client? |  |

The Devon Advocacy Consortium is a partnership made up of 4 specialist advocacy providers: Living Options Devon (lead), Rethink Advocacy, Vocal Advocacy and Young Devon.

Devon Advocacy Consortium

Living Options Devon

Units 3-4 Cranmere Court

Lustleigh Close

Matford Business Park

Exeter

EX2 8PW