**Independent Mental Capacity Advocacy Services Referral Form**

**South Gloucestershire**

**SWAN IMCA service represents and supports individuals in South Glos who meet all the following criteria:**

**The person referred has no appropriate family or friends to represent them and the referrer believes that they lack the capacity, decision specific, concerning:**

**a. Serious medical treatment OR**

**b. Long term accommodation moves (more then 28 days in hospital/8 weeks in a care home) OR**

**c. Care reviews or**

**d. Safeguarding measures within an adult protection case even where there are family or friends to consult with.**

***Please complete all sections otherwise the referral will be returned to you and will delay the referral being processed; this includes the monitoring questions at the end of the form.***

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **REFERRER DETAILS** | | | | | | | |
| Name; Dr/Mr/Mrs/Miss/Ms | | | | | | | |
| Job Title & Organisation | | | | | | | |
| Address  Postcode | | | | | | | |
| Landline; | | Mobile; | | | | Email address | |
| **CLIENT INFORMATION** | | | | | | | |
| Full name: | Known as: | | | | | | Date of birth |
| Address at point of referral  Postcode:  Tel no:  Contact Name at Referral Address: | | | | | Home address (if different)  Postcode:  Home tel no:  Contact Name at Home address | | |
| **Nature of illness or impairment**  **(please indicate one or**  **more as appropriate)**   * Learning disability * Mental Illness * Dementia * Serious Physical Illness * Acquired Brain Injury * Unconscious State * Other – Please give brief description | | | | **Preferred communication method**  **(please indicate and give brief details as appropriate)**   * English * Another Spoken Language * Pictures/Symbols * Makaton/British Sign Language * Gestures/Vocalisations/Facial expressions * No Obvious Communication * Other – Please specify | | | |
| **Who is the IMCA decision maker?**  The decision maker is the individual within either the local authority or the NHS body who has the responsibility for making the decision on issues of change of accommodation or serious medical treatment on behalf of the client who has been assessed as lacking capacity on either issue. A third party can make the referral if they have the permission of the decision maker to do so.  **DECISION- MAKER Details (if different from Referrer) Required for Change of accommodation or Serious Medical Treatment** | | | | | | | |
| Name: Dr/Mr/Mrs/Miss/Ms | | | Name: Dr/Mr/Mrs/Miss/Ms | | | | |
| Job title & Organisation | | | | | | | |
| Address  Postcode | | | | | | | |
| Landline no. | | Mobile no. | | | | Email address; | |
| **Person to contact to arrange meeting with client**; | | | | | | | |

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| --- | --- | --- | --- |
| **CAPACITY ASSESSMENT – we can only accept an IMCA referral when a recent, decision specific, capacity assessment has taken place AND A COPY IS RETURNED WITH THIS REFERRAL FORM**  Has this client been formally assessed to lack capacity? Yes/No  A decision specific capacity assessment was completed on …… / …… /….  Name & Job Title of Assessor: | | | |
| **DECISION TO BE MADE:**   * Serious Medical Treatment * Change in Accommodation * Care Review * Safeguarding – has a Local Authority Section 42 enquiry been opened? Yes/No\*   \*If no then we are unable to provide our advocacy service | Please provide details as relevant: | | |
| **Please provide any important deadlines or meeting dates:** | | | |
| **Are there any risks that we should be aware of when visiting or arranging to meet with the client** eg. Pets at the home, Substance/Tobacco use, Behavioural issues, Neighbourhood concerns, Risk of self harm/Suicide, other members of the household | | | |
| **Does the client have family or close friends appropriate to consult with? Yes/No**  **If there are family or friends why is an IMCA needed?** | | | |
| **Please provide names and contact details of anyone else who can help form a true picture of the client’s wishes and feelings:** | | | |
| **Signature of the decision-maker or authorised person:**  NB If an electronic signature isn’t used, the return of this form is a presumption of a signature | | **Print Name:** | **Date:** |

**The information on this page is required for service monitoring purposes only**

**but is a compulsory section of this referral form**

**Please tick as appropriate**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client’s Ethnic Origin** | | **Client’s Religion or Belief** | | | | **Language** | | | |
| White British |  | Bahi | | |  | What is your first language? | |  | |
| Any other white background |  | Buddhism | | |  |  | |  | |
| Black/African/Caribbean |  | Christianity | | |  |  | |  | |
| Mixed and Multiple ethnic groups |  | Hinduism | | |  |  | |  | |
| Asian |  | Humanism | | |  |  | |  | |
| Other ethnic Group |  | Islam | | |  |  | |  | |
| Prefer not to say |  | Judaism | | |  |  | |  | |
|  |  | Paganism | | |  |  | |  | |
|  |  | Sikhism | | |  |  | |  | |
|  |  | Other | | |  |  | |  | |
|  |  | Prefer not to say | | |  |  | |  | |
|  |  | Not asked | | |  |  | |  | |
|  |  |  | | |  |  | |  | |
| **Gender** | | | | | | | | | |
| **Do you identify;-** |  | **Does your gender identity match completely the sex you were registered at birth?** | | **Sexual Orientation** | | | | |  |
| As a woman |  | Bisexual | | | | |  |
| As a man |  | Gay | | | | |  |
| In some other way |  | Yes |  | Heterosexual | | | | |  |
| Prefer not to say |  | No |  | Lesbian | | | | |  |
|  |  | Prefer not to say |  | Other | | | | |  |
|  |  |  |  | Prefer not to say | | | | |  |
|  |  |  | |  | | | | | |
|  |  |  | |  | | | | | |
| **Carers** | | | | | | | | | |
| Do you provide care for anyone (eg a parent, child, other relative, an elderly person, friend or neighbour) who has a form of disability | | | | | | | Yes | |  |
| No | |  |
| Prefer not to say | |  |