**IMCA 1:2 Rule Referral Form – Pan Dorset**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referrer Details** | | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | | | | | | | | | | | | | | | |
| Job Title: | | | | |  | | | | | Organisation: | | | | | | |  | | | |
| Address: | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Tel No: | |  | | | | | | Email: |  | | | | | | | | | | | |
| **Client Information** | | | | | | | | | | | | | | | | | | | | |
| Name: | | |  | | | | | | | Date of Birth: | | | | | DD/MM/YYYY | | | | | |
| Address at referral: | | | | | | | | | | Home address: (if different) | | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | |
| Postcode: | | |  | | | | | | | Postcode: | | | | | |  | | | | |
| Tel No. | | | |  | | | | | | Tel No. | | | |  | | | | | | |
| **Preferred Communication method (please indicate and give brief details as appropriate)** | | | | | | | | | | | | | | | | | | | | |
|  | English | | | | | | | | |  | | | British Sign Language | | | | | | | |
|  | Other spoken language | | | | | | | | |  | | | No obvious communication | | | | | | | |
|  | Pictures/symbols/Makaton | | | | | | | | |  | | | Gestures/vocalisations/facial expressions | | | | | | | |
|  | Other | | | | | | | | |  | | | | | | | | | | |
| If other, please specify: | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Details of Relevant Professionals** | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | | | | | | **Address:** | | | | | | | | | | | **Connection to Client:** | | |
|  | | | | | | |  | | | | | | | | | | |  | | |
|  | | | | | | |  | | | | | | | | | | |  | | |
|  | | | | | | |  | | | | | | | | | | |  | | |
|  | | | | | | |  | | | | | | | | | | |  | | |
| **Capacity Assessment** | | | | | | | | | | | | | | | | | | | | |
| Has this client been formally assessed to lack capacity? | | | | | | | | | | | | | | | | | | | **Yes**  **No** | |
| A decision specific capacity assessment was completed on: | | | | | | | | | | | | | | | | | | | | DD/MM/YYYY |
| Name of Assessor: | | | | | |  | | | | | Job Title: | | | | |  | | | | |
| Please provide any important deadlines or meeting dates: | | | | | | | | | | | |  | | | | | | | | |
| Please briefly state the advocacy requirement: | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **In making this referral, I declare that:**   * **I wish to request advocacy support from South West Advocacy Network (SWAN).** * **I understand that client information supplied on this form will be stored safely on SWAN’s system.** * **I confirm that I am either a self-referring client or I have consent from the client to make the referral, or I have the authority to make the referral for the client.**   By requesting advocacy support, you give consent to SWAN sharing information where necessary for the purpose of providing this service. All data held by SWAN is held in accordance with the current UK General Data Protection Regulations legislation. | | | | | | | | | | | | | | | | | | | | |

**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** | | | | | | |
| White British | | |  | Bahi | | | |  | | |
| Any other white background | | |  | Buddhism | | | |  | | |
| Black/African/Caribbean | | |  | Christianity | | | |  | | |
| Mixed or 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** | | | | | | | | | | |
| **Is your gender the same as assigned at birth?** | | **Do you identify:** | | | | **Sexual Orientation** | | | | |
| Heterosexual | | |  | |
| Yes |  | As a woman | | |  | Gay | | |  | |
| No |  | As a man | | |  | Bisexual | | |  | |
| Prefer not to say |  | In another way | | |  | Lesbian | | |  | |
|  | | Prefer not to say | | |  | Other | | |  | |
|  | | | | Prefer not to say | | |  | |
|  | |  | | | |  | | |  | |
| **Carers** | | | | | | | | | | |
| Do you provide care for anyone (e.g. a parent, child, other relative, an elderly person, friend, or neighbour) who has a form of disability (sensory loss, physical, learning disability, mental health problem), long term health issues or terminal illness? | | | | | | | Yes | | |  |
| No | | |  |
| Prefer not to say | | |  |