**Independent Mental Capacity Advocacy Service Referral Form – Pan Dorset**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SWAN IMCA service represents and supports individuals across Dorset, Bournemouth, Christchurch and Poole 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:**   1. **Serious medical treatment OR** 2. **Long term accommodation moves (more than 28 days in hospital/8 weeks in a care home)**   ***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.*** | | | | | | | | | | | | | | | | | | |
| **Referrer Details** | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | | | | | | | | | Title: | | Choose an item. | | |
| Job Title: | | | | |  | | | | | Organisation: | | | | |  | | | |
| Address: | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Landline: | | |  | | | | | | Mobile: | | | | |  | | | | |
| Email Address: | | | | | |  | | | | | | | | | | | | |
| **Client Information** | | | | | | | | | | | | | | | | | | |
| Name: | | |  | | | | | | Date of Birth: | | | | DD/MM/YYYY | | | | | |
| Address at referral: | | | | | | | | | Home address: (if different) | | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | |
| Postcode: | | |  | | | | | | Postcode: | | | | |  | | | | |
| Tel No.  Mobile No. | | | |  | | | | | Tel No.  Mobile 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: | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **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.**  In exceptional circumstances SWAN may consider older evidence if the rationale is clearly identified. | | | | | | | | | | | | | | | | | | |
| 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: | | |  | | | | |
| Does the client have family or close friends appropriate to consult?  **Yes**  **No** | | | | | | | | | | | | | | | | | | |
| If there are family or friends, why is an IMCA needed? | | | | | | | | | | | | | | | | | | |
| **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: | |  | | | | | | | | | | | | Title: | | Choose an item. | | |
| Job Title: | | | | |  | | | | | Organisation: | | | | |  | | | |
| Address: | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Landline: | | |  | | | | | | Mobile: | | | | |  | | | | |
| Email Address: | | | | | |  | | | | | | | | | | | | |
| **DECISION TO BE MADE**  Serious Medical Treatment  Change in Accommodation | | | | | | | | | | | | | | | | | | |
| Please provide names and contact details of anyone else who can help form a true picture of the client’s wishes and feelings: | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **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 | | | |  | | |
| Not asked | | |  | 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 | | |  | |
| Not asked |  | Prefer not to say | | |  | Other | | |  | |
|  | | Not asked | | |  | Not asked | | |  | |
|  | |  | | | |  | | |  | |
| **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 | | |  |
| Not asked | | |  |