**IMHA Referral Form – Portsmouth Residents**

**NB: SWAN can only accept a referral if the person needing an advocate has given their consent. If you believe they do not have the capacity to consent, please give brief details on the ‘additional information’ section of this form.**

***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.***

|  |  |
| --- | --- |
| Are you asking for an advocate for yourself? Yes/No | If Yes, how did you hear of SWAN? |
| If you are asking for an advocate for someone else, have they given their consent? Yes/NoIf you are asking for an advocate for someone else, please complete the ‘Client information’ and ‘Referrer information’ sections of this form.  |
| May we contact the client directly? Yes/No If not, whom should we contact?  |
| **Referrer information (if other than the client)** |
| **Full name** | **Job title (if appropriate)** |
| **Address:****Postcode:** | **Tel. no:****Email address:** |
| **Relationship to client:** |
| **Client information (the client is the adult who is in need of an advocate)** |
| **Name Mr/Mrs/Miss:** | **Date of birth:** |
| **Address at point of referral (eg. Hospital):****Postcode:****Phone no at point of referral:** | **Please tick any criteria which apply to the client:** * Learning Disability
* Physical Disability
* Mental Ill Health
* Sensory Impairment
* Aging (Over 60)
* Dementia
* Acquired Brain Injury
* Autistic Spectrum Disorder
 |
| **Home address (if different from above):****Postcode:****Home phone no:****Mobile no:** **Email:** | **Is the client: (please indicate eligibility)*** Detained under MHA Sec 2\_\_\_/Sec 3 \_\_

Date of Section \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Subject to SCT (Supervised community treatment)
* Subject to a Guardianship order
* Subject to a restricted conditional discharge
* Considered for Section 57 treatment
* Under 18 & considered for ECT
* Under 18 and considered for sec 58A
 |
| **Does the client have any special needs we should consider when visiting, or arranging to meet with them:** (e.g. do they have difficulty in communicating verbally/in writing?) |
| **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 |
| **Please state any pertinent information about the client – any information will be shared with the client unless the client is deemed not to have the capacity to instruct:** |
| **CONSENT****Due to the Data Protection Act 1998, we need signed authorisation to say that the individual agrees to SWAN holding personal information (including the information provided on this referral)**NB If an electronic signature isn’t used, the return of this form is a presumption of a signature |
| **Signed Referrer: Signed Client:****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** | **Sexuality** |
| **Client identifies as:** | **Client identifies as:** |
| Male |  | Queer |  |
| Female |  | Bisexual |  |
| Trans Man |  | Pansexual |  |
| Trans Woman |  | Gay |  |
| Intersex |  | Lesbian |  |
| Non-Binary |  | Heterosexual |  |
| Genderqueer |  | Asexual |  |
| Other |  | Other |  |
| Prefer not to say |  | 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 (sensory loss, physical, learning disability, mental health problem) long or terminal illness? | Yes |  |
| No |  |
| Prefer not to say |  |