**Independent Mental Health Advocate (IMHA) Referral form**

AfA provides the Advocacy for Sutton IMHA service.

This form can be used by: Patients, Professionals or Nearest Relatives to refer

Qualifying IMHA Patients

Alternatively, referrals can be made by telephone on 0345 310 1812

Advocacy for All is totally independent from statutory organisations and all other service delivery and is free from conflict of interest.

***If completing online, click once on relevant box to check. Write in text fields, where required.***

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| **Date of Referral:** |
| **REFERRER’S DETAILS** |
| **Are you making this referral for yourself? (self-referral)** [ ]  YES [ ]  NO**If NO**, provide referrer details below. ( **If YES**, go to SERVICE GROUP )  |
| **Referrer First Name:**  | **Last Name:** |
| **Are you referring on a Professional basis?**  |  [ ]  Yes [ ]  No |
| **Organisation** (if applicable):  |
| **Job Title or Relationship to Patient:** |
| [ ]  Doctor | [ ]  Psychiatrist | [ ]  Ward Manager |
| [ ]  Care Manager | [ ]  Care Home Manager | [ ]  Team Manager Health |
| [ ]  Nurse / Health Professional | [ ]  Social Worker (Hospital) | [ ]  Social Worker (Community) |
| [ ]  Team Manager Social Care | [ ]  AMHP |  |
| [ ]  Other / Non Professional Relationship (specify)  |
| **Address:** |  |
| **Postcode:** |
| **Tel No:** | **Mobile No:** |
| **Email:** |

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| **PATIENT INFORMATION**  |
| **Title:** [ ]  Mr [ ]  Mrs[ ]  Ms [ ]  Other  | **First Name:** **Last Name:**  |
| **Date of Birth:**  |
| **Permanent Address:**  |  |
| **Postcode:** |
| **Telephone No.** | **Mobile No.** |
| **E-mail** |

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| **Preferred method of contact:** [ ]  Any [ ]  Mobile Phone | [ ]  Telephone[ ]  Text | [ ]  E-mail [ ]  Post[ ]  Cannot be contacted directly |
| **Gender:** [ ]  Male [ ]  Female [ ]  Transgender M to F [ ]  Transgender F to M [ ]  Prefers not to say [ ]  Other (specify)  |
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| **Ethnic Background**  |
| **White**  [ ]  British  [ ]  Irish  [ ]  Gypsy or Irish Traveller  [ ]  Any other White background (specify)  **Mixed Ethnic Groups** [ ]  White & Black Caribbean [ ]  White & Black African [ ]  White & Asian [ ]  Any other Mixed ethnic background (specify)  **Black / Black British** [ ]  African [ ]  Caribbean [ ]  Any other Black/African/Caribbean background (specify) | **Asian / Asian British** [ ]  Indian [ ]  Pakistani [ ]  Bangladeshi [ ]  Chinese [ ]  Any other Asian background (specify) **Other Ethnic Group** [ ]  Arab [ ]  Any other ethnic group (specify)  [ ]  Ethnicity not known [ ]  Prefers not to say    |
| **Sexual Orientation**  |
|  [ ]  Lesbian [ ]  Gay Man [ ]  Heterosexual [ ]  Bisexual [ ]  Other (specify)   [ ]  Questioning [ ]  Not known [ ]  Prefers not to say  |
| **Marital or Civil Partnership Status**  |  |
|  [ ]  Single [ ]  Co-habiting [ ]  Married [ ]  In Civil Partnership [ ]  Not known  | [ ]  Separated (but still legally married / in civil partnership)[ ]  Divorced or Civil Partnership Dissolved[ ]  Widowed [ ]  Surviving partner of Civil Partnership[ ]  Prefers not to say |
| **Religion or Belief** |  |
|  [ ]  Buddhist [ ]  Christian (all denominations)  [ ]  Hindu [ ]  Jewish [ ]  Not known  | [ ]  Muslim[ ]  Sikh[ ]  No Religion[ ]  Other (specify)  [ ]  Prefers not to say |
| **Does the Patient have a Military connection?**  |
|  [ ]  Yes, Serving  [ ]  No  |  [ ]  Yes, Veteran [ ]  Not known | [ ]  Yes, Carer relationship[ ]  Prefers not to say |
| **Does the Patient consider themself to have a disability?**  |
|  [ ]  Yes  [ ]  Not known | [ ]  No[ ]  Prefers not to say  |
| **What types of disability or impairment does the Patient have? (select *all* that apply)** |
|  [ ]  Mental Health Problem [ ]  Physical Disability  [ ]  Sensory (Hearing)  [ ]  Sensory (Sight)  [ ]  Asperger's / Autism Spectrum Condition  [ ]  Cognitive Impairment  | [ ]  Acquired Brain Injury[ ]  Serious Physical Illness[ ]  Learning Disability[ ]  Dementia / Alzheimer’s[ ]  Unconsciousness[ ]  Other (please specify below) |
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| **What is the Patient’s primary communication method?** |
|  [ ]  Spoken English [ ]  British Sign Language (BSL) [ ]  Words/Pictures/Makaton  | [ ]  Other Spoken Language (specify) [ ]  Gestures/Facial Expressions/Vocalisations[ ]  No obvious means of communication [ ]  Not known   |
|  [ ]  Other (specify)  |
| **Is English Spoken?** [ ]  Yes [ ]  No |

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| **PATIENT LOCATION DETAILS**  |
| **Patient’s current location** |
|  [ ]  Own Home [ ]  Own Home with Support  [ ]  Supported Living [ ]  Acute Psychiatric Unit  |  [ ]  Dementia Ward [ ]  Care / Nursing home [ ]  Prison [ ]  Forensic Secure Unit  | [ ]  Hospital [ ]  Homeless[ ]  No Fixed Abode[ ]  Other Institution |
| **Is patient currently at their permanent address?** [ ]  Yes [ ]  No **If No, give details below:** |
| **Current Address:**  |  |
| **Postcode:** |
| **Telephone No.** |
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| **Ward Name** (if in Hospital)**:** |
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| **IMHA REFERRAL DETAILS** |
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| **Qualifying Patients:** This includes detained patients (excluding those subject to sections 4, 5(2), 5(4), 135 and 136), even if they are on leave or conditionally discharged. This also includes patients on s.17A Community Treatment Orders, s.7 Guardianship and informal patients under 18 who are being considered for ECT (for full eligibility, see Chapter 6 of the Mental Health Act 1983, Code of Practice). Patients with capacity must either consent to the referral OR the Responsible Clinician, AMHP or Nearest Relative believe that the patient might benefit from IMHA support but are unable or unlikely, for whatever reason, to request this for themself. All patients who lack capacity to decide whether or not to obtain help from an IMHA must be referred to the service. |
| **The Patient is a Qualifying Patient** [ ]  Yes |
| **To which section of the MHA is the patient subject (if known inc Guardianship & CTO)?** |
| **Is patient subject to any further (i) section of the MHA (if known)?****Is patient subject to any further (ii) section of the MHA (if known)?** |
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| **The Patient is an Informal Inpatient** [ ]  Yes**Being considered for a treatment to which the special rules in s57 of the Act apply** [ ]  Yes**(neurosurgery);** |
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| **Is the patient subject to Section 117 Aftercare?**  [ ]  Yes [ ]  No [ ]  Don’t know |
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| **Has the patient consented to this referral?** [ ]  Yes [ ]  No  |

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| **Name of Responsible Clinician / Consultant Psychiatrist:**  |

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| **Date of Detention (if applicable):** |

**What is the issue / situation requiring an advocate?**

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| **Is the patient subject to seclusion?**  [ ]  Yes [ ]  No |

**Are there any deadlines or important meeting dates?**

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**Are there any risk factors of which the advocate should be aware?**

**If you are not aware of any risks, please write 'no known risks'**

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| **Does the patient have capacity to request / instruct an advocate?**  [ ]  Yes [ ]  No |
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| **Permission to Share:** Can an advocate be contacted in the event of discharge into Guardianship or Community Treatment Order? | [ ]  Yes [ ]  No |

**Declaration:**

* I declare that I wish to instruct an IMHA.
* I am providing this information and making this referral in relation to the Mental Health Act 1983.
* In accordance with the Data Protection Act 1998, I agree to the Advocacy for Bromley delivery partners holding personal information (including information on this form).
* I understand the provision of an advocacy service is subject to the patient meeting eligibility criteria.

**Please e-mail the completed form to:** **referrals@advocacyforall.org.uk**

or post to: **Advocacy for All, The Civic Centre, St Mary's Road, Swanley BR8 7BU**

If you have not received confirmation of this referral within 2 working days,

please ring: **0345 310 1812 opt 2** or e-mail: **referrals@advocacyforall.org.uk**

By requesting advocacy support, you give consent to Advocacy for All providers sharing information, as required for the purposes of providing the service.

For more information on our Privacy Policy, please ask your advocate.

All records are held by AfA in accordance with current Data Protection legislation.