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

Advocacy for All provides advocacy for the Bromley IMHA service

This form can be completed by professionals, or nearest relatives

Patients may also refer themselves directly to the IMHA service

Alternatively, referrals can be made by telephone on 0345 310 1812 – option 2

**Eligibility for service users:**

**Please tick which of the below applies to you or your client**

Service users, in a Bromley hospital where they are being detained, (except for individuals under sections 4, 5, 135 and 136)

Service users on a CTO discharged in the Bromley community.

Service users are subject to guardianship

**Other service users (informal patients) are eligible if they are:**

Being considered for a treatment to which section 57 applies (‘a section 57 treatment’)

Under 18 and being considered for electro-convulsive therapy (ECT) or any other treatment to which section 58A applies (‘a section 58A treatment’).

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:** Click or tap here to enter text. | | | | | |
| **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:** Click or tap here to enter text. | | | **Last Name:** Click or tap here to enter text. | | |
| **Are you referring on a Professional basis?** | | | Yes  No | | |
| **Organisation** (if applicable): Click or tap here to enter text. | | | | | |
| **Job Title or Relationship to Patient:** Click or tap here to enter text. | | | | | |
| 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 | | Administrator | | |  |
| Other / Non Professional Relationship (specify) Click or tap here to enter text. | | | | | |
| **Address:** | Click or tap here to enter text. | | | | |
| **Postcode:** Click or tap here to enter text. | | | | | |
| **Tel No:** Click or tap here to enter text. | | | | **Mobile No:** Click or tap here to enter text. | |
| **Email:** Click or tap here to enter text. | | | | | |
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| **SERVICE GROUP** | | | | | | | | |
| **Is there a *main* disability or impairment considered particularly relevant to this case? (check *ONE* box only)** | | | | | | | | |
| Mental Health  Physical Disability  Sensory (Hearing)  Sensory (Sight) | | | Asperger’s /Autism  Cognitive Impairment  Acquired Brain Injury  Serious Physical Illness | | | | | Learning Disability  Dementia / Alzheimer’s  Unconsciousness  **NO** |
| **PATIENT INFORMATION** | | | | | | | | |
| **Title:**  Mr  Mrs  Ms  Other Click or tap here to enter text. | | | | | **First Name:** Click or tap here to enter text.  **Last Name:** Click or tap here to enter text. | | | |
| **Date of Birth:** Click or tap here to enter text. | | | | | | | | |
| **Permanent Address:** | | Click or tap here to enter text. | | | | | | |
| **Postcode:** Click or tap here to enter text. | | | | | | | | |
| **Telephone No.** Click or tap here to enter text. | | | | | | **Mobile No.** Click or tap here to enter text. | | |
| **E-mail** Click or tap here to enter text. | | | | | | | | |
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| **PATIENT LOCATION DETAILS** | | | | | | | | |
| **Patient’s current location** | | | | | | | | |
| Own Home  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:** | Click or tap here to enter text. | | | | | | | |
| **Postcode:** Click or tap here to enter text. | | | | | | | | |
| **Telephone No.** Click or tap here to enter text. | | | | | | | | |
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| **Ward Name** (if in Hospital)**:** Click or tap here to enter text. | | | | | | | | |

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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) Click or tap here to enter text. | | |
| **Ethnic Background** | | | | | |
| **White**  British  Irish  Gypsy or Irish Traveller  Any other White background (specify)  Click or tap here to enter text.  **Mixed Ethnic Groups**  White & Black Caribbean  White & Black African  White & Asian  Any other Mixed ethnic background (specify)  Click or tap here to enter text.  **Black / Black British**  African  Caribbean  Any other Black/African/Caribbean background (specify)  Click or tap here to enter text. | | | | | **Asian / Asian British**  Indian  Pakistani  Bangladeshi  Chinese  Any other Asian background (specify)  Click or tap here to enter text.  **Other Ethnic Group**  Arab  Any other ethnic group (specify)  Click or tap here to enter text.  Ethnicity not known  Prefers not to say |
| **Sexual Orientation** | | | | | |
| Gay Man  Gay Women  Heterosexual  Other (specify) Click or tap here to enter text. | | | Bisexual  Not known  Prefers not to say | | |
| **Religion or Belief** | |  | | | |
| Buddhist  Christian (all denominations)  Hindu  Jewish  Not known | | Muslim  Sikh  No Religion  Other (specify) Click or tap here to enter text.  Prefers not to say | | | |

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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)  Click or tap here to enter text.  Gestures/Facial Expressions/Vocalisations  No obvious means of communication  Not known | |
| Other (specify) Click or tap here to enter text. | | |
| **Is English Spoken?**  Yes  No | | |
| **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 | | |
| **Which section of the MHA is the patient subject (if known)?** Click or tap here to enter text. | | |
| **Is patient subject to any further (i) section of the MHA (if known)?**  Click or tap here to enter text.  **Is patient subject to any further (ii) section of the MHA (if known)?**  Click or tap here to enter text. | | |
| **Informal Inpatients:** Although informal inpatients and those detained on short term / emergency sections do not have a legal right to an IMHA, an advocate may be able to provide advocacy on an informal basis, subject to availability. | | |
| **The Patient is an Informal Inpatient**  Yes | | |
| **Is the patient subject to Section 117 Aftercare?**   Yes  No  Don’t know | | |
| **Has the patient consented to this referral?**  Yes  No | | |
| **Name of Responsible Clinician / Consultant Psychiatrist:**  Click or tap here to enter text. | | |
| **Date of Detention (if applicable):** Click or tap here to enter text. | | |
| **What is the issue / situation requiring an advocate?**  Click or tap here to enter text. | | |
| **Is the patient subject to seclusion?**  Yes  No | | |
| **Are there any deadlines or important meeting dates?**    Click or tap here to enter text. | | |
| **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'  Click or tap here to enter text. | | |
| **Does the patient have capacity to request / instruct an advocate?**   Yes  No | | |
| **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**](mailto:referrals@advocacyforall.org.uk)

Or post to: Advocacy for Bromley, 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 – option 2 for referrals or e-mail: [**referrals@advocacyforall.org.uk**](mailto:referrals@advocacyforall.org.uk)

By requesting advocacy support, you give consent to Advocacy for Bromley 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 Advocacy for All in accordance with current Data Protection legislation.



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