IMCA & Care Act

Referral Form

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| If you require assistance to complete this form please read the separate Guidance.**For all referrals please complete: PART 1, PART 2 and sign PART 3.****Additionally complete SECTION H for IMCA or SECTION I for Care Act.**The more information you give us, the quicker we can process the referral and avoid delays. Please indicate below which service you are requesting IMCA or Care Act: |
| **Independent Mental Capacity Advocacy (IMCA)** (please tick box and answer below) |[ ]
| Does the person lack capacity in relation to the referral issue? (has an impairment or disturbance in the functioning of the brain which means the person cannot understand, retain or weigh up information, or communicate their wishes or feelings) If not, referral would not be eligible for the IMCA service | Yes [ ]  No [ ]  |
| For IMCA referrals the advocate will require the capacity assessment for the decision, please tick the box if you have attached with referral. | Yes [ ]  No [ ]  |
| Is there anyone (e.g. friend/relative) who can be consulted about the issue, or support the person’s involvement? If yes, please advise reason for referral. Click or tap here to enter text. | Yes [ ]  No [ ]  |
| **Independent Care Act Advocacy (ICAA)** (please tick box and answer below) |[ ]
| Does the person have substantial difficulty in engaging with, or understanding the referral issue? (This can mean difficulty understanding, retaining, using/ weighing up information or communicating their wishes and feelings) If not, referral would not be eligible for the Care Act serviceClick or tap here to enter text. | Yes [ ]  No [ ]  |
| Does the person have anyone available to facilitate their involvement? If yes, please advise reason for referral. Click or tap here to enter text.  | Yes [ ]  No [ ]  |
| **Part 1 Consent and Capacity** |
| **Section A** | **Consent** |
| If on behalf of someone do they know this referral is being made? | Yes [ ]  No [ ]  |
| Do they consent to the referral? | Yes [ ]  No [ ]  |
| May we contact them directly? | Yes [ ]  No [ ]  |
| Does the person agree to AFA being given copies of relevant documents? | Yes [ ]  No [ ]  |
| **Capacity** |
| If the person lacks capacity to accept/decline advocacy support, please confirm that you are referring in their best interests (it would be good practice to inform the person of the referral where possible) | Yes [ ]  No [ ]  |
| Does the client have an attorney, receiver or guardian?  | Yes [ ]  No [ ]  |
| Please give name and telephone number and clarify the issue that they are dealing with: Click or tap here to enter text. |
| **Section B** | **Details of person needing advocacy** |
| Title | Click or tap here to enter text. | Full name | Click or tap here to enter text. |
| Name known as (if different) | Click or tap here to enter text. |
| **Date of birth** | Click or tap here to enter text. | **Referrer reference Number** | Click or tap here to enter text. |
| Address at time of referral | Click or tap here to enter text. |
|  | Postcode | Click or tap here to enter text. |
| Telephone number | Click or tap here to enter text. | Mobile number | Click or tap here to enter text. |
| Email  | Click or tap here to enter text. |
| Other address (if relevant): | Click or tap here to enter text. |
|  | Postcode | Click or tap here to enter text. |
| Please specify location type | Own Home [ ]  Residential Home [ ]  Nursing Home [x]  Supported Living [ ]  Hospital [ ]  Other (please specify) Click or tap here to enter text. |
| Funding Authority | Click or tap here to enter text. |
| **Section C** | **Equality and Diversity** |
| **Diversity is important to us. We collate information to help us shape our services to represent the needs of our communities and to fight for a fairer society. If you are referring someone, please discuss how they describe themselves and complete. We will keep this information confidential and will only use it anonymously.** |
| **Gender: Which option best describes how the person thinks about themselves?** |
| Woman |[ ]  Man |[ ]  Transgender | [ ]  | Non Binary | [ ]  |
| Intersex |[ ]  Prefer not to say |[ ]  Other  |[ ]  Click or tap here to enter text. |
| **Disability** *(cross all boxes that apply)* |
| **Does the person have a disability, long-term health condition or any additional needs****Please choose one:**Choose an item.**Secondary issue:**Choose an item.**If other please specify:**  Click or tap here to enter text. |
| **Primary language**  | Choose an item. |
| **Sexuality: Which option best describes how the person thinks about themselves?** |
| **Choose one:**Choose an item. |
| **Other (please describe)** | Click or tap here to enter text. |
| **Ethnic origin: Which option best describes the persons ethnic group or background**  |
| **Choose one:**Choose an item. |
| **If other please specify** | Click or tap here to enter text. |
| **Religion/belief: Which group does the person most identify with?** |
| **Choose one:**Choose an item. |
| **If other please specify** | Click or tap here to enter text. |
| **Section D** | **Person making the referral**  |
| Full name | Click or tap here to enter text. |
| Job title  | Click or tap here to enter text. |
| Organisation  | Click or tap here to enter text. |
| Address | Click or tap here to enter text. |
|  | Postcode | Click or tap here to enter text. |
| Telephone number | Click or tap here to enter text. | Mobile number | Click or tap here to enter text. |
| Email  | Click or tap here to enter text. |
| Relationship to person being referred  | Click or tap here to enter text. |
| Where did you hear about Advocacy for All | Click or tap here to enter text. |
| **Section E** | **Please outline reason for referral**  |
| Click or tap here to enter text. |
| Are there any urgent meetings planned? (give details): | **Yes** |[ ]  **No** |[ ]
| Click or tap here to enter text. |
| Are there any safeguarding issues? (give details): | **Yes** |[ ]  **No** |[ ]
| Click or tap here to enter text. |
| **Section F** | **Key people If relevant to referral** |
| **GP**  | First name | Click or tap here to enter text. | Last name | Click or tap here to enter text. |
| Surgery | Click or tap here to enter text. |
| Surgery address  | Click or tap here to enter text.  |
|  | Postcode | Click or tap here to enter text. |
| Telephone number | Click or tap here to enter text. | Email | Click or tap here to enter text. |
| **Consultant** (if any) | First name | Click or tap here to enter text. | Last name | Click or tap here to enter text. |
| Consultant address  | Click or tap here to enter text.  |
|  | Postcode | Click or tap here to enter text. |
| Telephone number | Click or tap here to enter text. | Email | Click or tap here to enter text.  |
| **Social worker or Care Manager/ Coordinator** | First name | Click or tap here to enter text. | Last name | Click or tap here to enter text. |
| Team | Click or tap here to enter text. |
| Social Worker/Care Coordinator address  | Click or tap here to enter text.  |
|  | Postcode | Click or tap here to enter text.  |
| Telephone number | Click or tap here to enter text. | Email | Click or tap here to enter text. |
| **Name of Responsible Clinician** | Click or tap here to enter text. |
| **Name of Nearest Relative (if any)** | Click or tap here to enter text. |
| **Other key people involved** **(if any)** | Click or tap here to enter text. |
| **Section G** | **Risk information (Referral cannot be processed without risk information)** |
| No known risk |[ ]  Risk has been identified |[ ]  Confirm risk assessment is attached (e.g. FACE) |[ ]
| **If risk has been identified, provide details, including anything we should know to make sure the person and the Advocate remain safe.** |
| Click or tap here to enter text. |
| **Part 2: Which advocacy service are you referring to?** |
| **Section H** | **Independent Mental Capacity Advocacy (IMCA)**  |
| **The decision to be made in this case relates to** *(please cross box that applies)*:  |
| **\*Serious medical treatment,** please indicate below treatment being referred for. | **Yes** |[ ]
| **Change of accommodation**:NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home, and* the person will stay in hospital for 28 days or more
* the person will stay in accommodation for 8 weeks or more
 | **Yes** |[ ]
| **\*Care Review** in relation to a previous/recent change of accommodation arrange by the state (i.e local authority). **Please indicate in the box below how long the client has resided at the current accommodation.**Click or tap here to enter text.  | **Yes** |[ ]
| **\*Safeguarding Adults proceedings** If yes, please state whether the client referred is:**Please select one:** Choose an item.The person may have family and still be eligible for IMCA in this instance. \***Please indicate what the protective measures are in the box below.**Click or tap here to enter text. | **Yes** |[ ]
| **Any additional information:** |
| Click or tap here to enter text. |
| I confirm that I am the Decision Maker for this issue |[ ]  Are you also the Referrer |[ ]
| I confirm that I deem this person to be un-befriended, with no-one appropriate to consult regarding this decision (unless this is a safeguarding issue) |[ ]
| I confirm the person being referred has been deemed to lack capacity to make **this decision.** |[ ]
| I confirm that a capacity assessment for this decision was done. |[ ]  Date | Click or tap here to enter text. | Copy attached |[ ]
| **Decision Maker’s details****The decision maker must be relevant to the proposed decision. (i.e if COA the correct decision maker will be the local authority) Please see guidance on our website for further details.** |
| First name/s | Click or tap here to enter text. | Last name | Click or tap here to enter text.  |
| Job title | Click or tap here to enter text.  |
| Department/Team | Click or tap here to enter text. |
| Address |  Click or tap here to enter text. |
|  | Postcode | Click or tap here to enter text. |
| Telephone number | Click or tap here to enter text. | Mobile number | Click or tap here to enter text. |
| Email  | Click or tap here to enter text. | Fax number | Click or tap here to enter text. |
| **Section I** | **Independent Care Act Advocacy (ICAA)**  |
| Does the person have ‘substantial difficulty’ being involved | **Yes** |[ ]  **No** |[ ]
| Is there an ‘Appropriate Individual’ who can support the person’s involvement in the process (such as an existing advocate or unpaid family member or friend) | **Yes** |[ ]  **No** |[ ]
| **Issue that independent advocacy is required for** *(we can only accept referrals for adults for the issues below)*:  |
| Needs assessment | **Yes** |[ ]
| Preparation of care and support plan | **Yes** |[ ]
| Review of care and support plan | **Yes** |[ ]
| Carer’s assessment | **Yes** |[ ]
| Preparation of carers care and support plan | **Yes** |[ ]
| Review of carers care and support plan | **Yes** |[ ]
| A child’s transition to adult services assessments | **Yes** |[ ]
| Safeguarding enquiry | **Yes** |[ ]
| Safeguarding review | **Yes** |[ ]
| **Any additional information:** |
| Click or tap here to enter text.  |
| **Part 3: Signatures** |
| **Because of the Data Protection Act a signature is needed to say that you agree to Advocacy for All securely holding personal information (including the information on this form), on a computer and in a filing system. It is the policy of Advocacy for All that all personal data will be held in accordance with the principles and requirements of Data Protection and other relevant legislation, and that procedures will be put in place to ensure the fair processing of data relating to individuals. AFA is a confidential service.**  |
| **Referrer** |
| I agree that AFA can securely hold the client’s personal information as detailed above. I am providing this information with the client’s consent or in their best interests. |
| Name | Click or tap here to enter text. |
| Signature (not required if emailing) | Click or tap here to enter text. | Date | Click or tap here to enter text. |
| **Client/patient** |
| I agree that AFA can securely hold my personal information as detailed above.  |
| Name | Click or tap here to enter text. |
| Signature (not required if emailing) | Click or tap here to enter text. | Date | Click or tap here to enter text. |
| **Please check that you have completed all necessary parts of the form and attached ALL necessary information before returning the form to AFA. Emailed referrals are preferred as they can be processed quickly and without use of paper. Referrals are safe to send to this email address as it is encrypted**  |
| **Advocacy for All**Civic CentreSt Mary’s RoadSwanleyBR8 7BU | Email: referrals@advocacyforall.org.ukTelephone: 0345 310 1812Website: [www.advocacyforall.org.uk](http://www.advocacyforall.org.uk) |
| CHAS: The UK's No. 1 Contractor Health & Safety Assessment Scheme | Advocacy for All is an independent advocacy organisation and an equal opportunities employer.A Company Limited by Guarantee Registered in England No. 3407428 Registered Charity No. 1064855 |