Advocacy for patients detained under the Mental Health Act is a statutory right.
Independent Mental Health Advocates (IMHA) are specially trained professionals who work with eligible qualifying patients.

Please complete the referral form if (*please tick*):

|  |  |
| --- | --- |
|  | You would like to see an Independent Mental Health Advocate (*Self Referral*) … or |
|  | If you would like a patient in your care to see an Independent Mental Health Advocate (*Staff*) |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Relevant Person**: |  | Date of Birth: |  |
| Home Address: |  |
|  |
| Contact Number: |  | Is it ok to leave a message? |

|  |  |  |  |
| --- | --- | --- | --- |
| Yes |  | No |  |

 |
| Location or ward of Patient: |  |
| Ethnicity (*please tick)*: |
|

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| African |  | Bangladeshi |  | Black British |  | Caribbean |  |
| Chinese |  | Indian |  | Other |  | Other Asian |  |
| Other Black |  | Other Mixed Black |  | Other White |  | Pakistani |  |
| Sri Lankan |  | White & Black Carib. |  | White & Black Asian |  | White British |  |
| White Irish |  | Declined |  |  |  |  |  |

 |

|  |  |
| --- | --- |
| **Request for Referral Made By (*if not by patient*):** |  |
| Relationship to Individual: |  | Date of request: |  |
| Address: |  |
|  |
| Contact Number: |  | Email: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| If the referral request is by anyone other than the patient, has the patient agreed to this request: (*please tick*) |

|  |  |  |  |
| --- | --- | --- | --- |
| Yes |  | No |  |

 |
| If no, has the patient been formally assessed or is it otherwise believed that they lack the mental capacity to consent to the referral being made? (*please tick*) |

|  |  |  |  |
| --- | --- | --- | --- |
| Yes |  | No |  |

 |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Care Programme Approach: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Yes |  | No |  | Not Known |  |

 |

|  |
| --- |
| Patient is eligible for IMHA referral under: (*please tick appropriate section*): |
|

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Section: | 2 |  | 3 |  | 37 |  | G/ship |  | SCT/CTO |  | 57/58A |  |

 |
| Other: |  |
|  |

|  |
| --- |
| Details of situation that requires IMHA involvement: |
|  |

|  |
| --- |
| Please give details of any risks or behaviours we should be aware of: |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Does the patient have any communication needs? (*please tick*) |

|  |  |  |  |
| --- | --- | --- | --- |
| Yes |  | No |  |

 |
| If yes, please give more information: |
|  |

|  |
| --- |
| Please give details of any deadlines or important meeting dates: |
|  |

**For Office Use Only**

|  |  |
| --- | --- |
| Allocated Date: |  |
| Reference Number: |  |

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those purposes for which you have given your permission. A full copy of our
Privacy Statement is available at www.mindincroydon.org.uk*