IMCA & Care Act

Referral Form

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 below.	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.	Yes ☐ No ☐
Does the person have anyone available to facilitate their involvement? If yes, please advise reason for referral below and does all parties agree to the advocate request.	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 below and clarify the issue that they are dealing with:

Section B Details of person needing advocacy

Title		Full name	
Name known as (if different)			
Date of birth		**Referrer reference Number**	
Address at time of referral			
Postcode			
Telephone number		Mobile number	
Email			
Other address (if relevant):			
Postcode			
Please specify location type	Please Select		

Funding Authority	

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	☐	If other please specify	

Disability *(cross all boxes that apply)*

Does the person have a disability, long-term health condition or any additional needs

Please choose one:

Please Select

Secondary issue:

Please Select

If other please specify below:

Primary language	Please Select

Sexuality: Which option best describes how the person thinks about themselves?

Please Select

Other (please describe how the client identifies, identifies as female and transgender)	

Ethnic origin: Which option best describes the persons ethnic group or background

Please Select

If other please specify	

Religion/belief: Which group does the person most identify with?

Please Select

If other please specify	

Section D	**Person making the referral**		
Full name			
Job title			
Organisation			
Address			
	Postcode		
Telephone number		Mobile number	
Email			
Relationship to person being referred			
Where did you hear about Advocacy for All			

Section E	**Please outline reason for referral**

Are there any urgent meetings planned? (give details):	**Yes**	☐	**No**	☐
Are there any safeguarding issues? (give details):	**Yes**	☐	**No**	☐

Section F	**Key people If relevant to referral**			
GP	First name		Last name	
Surgery				
Surgery address				
	Postcode			
Telephone number		Email		
Consultant (if any)	First name		Last name	
Consultant address				
	Postcode			
Telephone number		Email		
Social worker or Care Manager/ Coordinator	First name		Last name	
Team				
Social Worker/Care Coordinator address				
	Postcode			
Telephone number		Email		
Name of Responsible Clinician				
Name of Nearest Relative (if any)				
Other key people involved (if any)				

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.

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.	Please Selec
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	Please Selec
***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.**	Please Selec
***Safeguarding Adults proceedings** If yes, please state whether the client referred is: **Please select one:** Please Selec 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.**	Please Selec

Any additional information:

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 has been completed.	☐	Date		I have attached the MCA with the referral.	☐

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		Last name	
Job title			
Department/Team			
Address			
Postcode			
Telephone number		Mobile number	
Email		Fax number	

Section I	**Independent Care Act Advocacy (ICAA)**
Does the person have 'substantial difficulty' being involved	Please Selec
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)	Please Selec

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:

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			
Signature (not required if emailing)		Date	

Client/patient

I agree that AFA can securely hold my personal information as detailed above.

Name			
Signature (not required if emailing)		Date	

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 Centre
St Mary's Road
Swanley
BR8 7BU

Email: referrals@advocacyforall.org.uk

Telephone: 0345 310 1812

Website: www.advocacyforall.org.uk