

## **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

### **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 by the local authority, which is acting as the guardian or, if the service user has a private guardian, by the local authority for the area in which the private guardian lives.

### **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.***

|                                                                                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Date of Referral:</b>                                                                                                                                    |  |
| <b>REFERRER'S DETAILS</b>                                                                                                                                   |  |
| <b>Are you making this referral for yourself? (self-referral)</b><br><b>If NO</b> , provide referrer details below. ( <b>If YES</b> , go to SERVICE GROUP ) |  |
| <b>Referrer Full Name:</b>                                                                                                                                  |  |
| <b>Are you referring on a Professional basis?</b>                                                                                                           |  |
| <b>Organisation (if applicable):</b>                                                                                                                        |  |
| <b>Job Title or Relationship to Patient:</b>                                                                                                                |  |
| <b>Address:</b>                                                                                                                                             |  |
| <b>Postcode:</b>                                                                                                                                            |  |
| <b>Tel No:</b>                                                                                                                                              |  |
| <b>Mobile No:</b>                                                                                                                                           |  |
| <b>Email:</b>                                                                                                                                               |  |

| SERVICE GROUP                                                                                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Is there a <u>main</u> disability or impairment considered particularly relevant to this case?</b><br><br><b>If other please specify:</b> |  |
| PATIENT INFORMATION                                                                                                                          |  |
| <b>Title:</b>                                                                                                                                |  |
| <b>Client Full Name:</b>                                                                                                                     |  |
| <b>Date of Birth:</b>                                                                                                                        |  |
| <b><u>Permanent</u> Address:</b>                                                                                                             |  |
| <b>Postcode:</b>                                                                                                                             |  |

|                                                                                              |  |
|----------------------------------------------------------------------------------------------|--|
| <b>Telephone No.</b>                                                                         |  |
| <b>Mobile No.</b>                                                                            |  |
| <b>E-mail</b>                                                                                |  |
| <b>PATIENT LOCATION DETAILS</b>                                                              |  |
| <b>Patient's current location</b>                                                            |  |
| <b>Is patient currently at their permanent address?</b><br><b>If No, give details below:</b> |  |
| <b>Current Address:</b>                                                                      |  |
| <b>Postcode:</b>                                                                             |  |
| <b>Telephone No.</b>                                                                         |  |
| <b>Ward Name</b> (if in Hospital):                                                           |  |

|                                                                                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Gender:</b><br><br>Other (please describe how the client identifies, i.e. identifies as female and transgender)            |  |
| <b>Ethnic Background</b><br><br>If Other please specify                                                                       |  |
| <b>Sexual Orientation</b><br><br>Other (please describe how the client identifies, i.e. identifies as female and transgender) |  |
| <b>Religion or Belief</b><br><br>If Other please specify                                                                      |  |
| <b>Patient's primary Language</b>                                                                                             |  |
| <b>Is English Spoken?</b>                                                                                                     |  |

| IMHA REFERRAL DETAILS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
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| <p><b>Qualifying Patients:</b> 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 themselves. All patients who lack capacity to decide whether or not to obtain help from an IMHA must be referred to the service.</p> |
| <p><b>The Patient is a Qualifying Patient</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <p><b>Which section of the MHA is the patient subject (if known)?</b><br/> <b>Is patient subject to any further (i) section of the MHA (if known)?</b><br/> <br/> <b>Is patient subject to any further (ii) section of the MHA (if known)?</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <p><b>Informal Inpatients:</b> 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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <p><b>The Patient is an Informal Inpatient</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <p><b>Is the patient subject to Section 117 Aftercare?</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <p><b>Has the patient consented to this referral?</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p><b>Name of Responsible Clinician / Consultant Psychiatrist:</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <p><b>Date of Detention (if applicable):</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <p><b>What is the issue / situation requiring an advocate?</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <p><b>Is the patient subject to seclusion?</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <p><b>Are there any deadlines or important meeting dates?</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <p><b>Are there any risk factors of which the advocate should be aware?</b><br/> <i>If you are not aware of any risks, please write 'no known risks'</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <p><b>Does the patient have capacity to request / instruct an advocate?</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <p><b>Permission to Share:</b><br/> Can an advocate be contacted in the event of discharge into Guardianship or Community Treatment Order?</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

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**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.

