



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				

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 <i>(cross all boxes that apply)</i>							
Does the person have a disability, long-term health condition or any additional needs Please choose one: Secondary issue: If other please specify below: 							
Primary language							
Sexuality: Which option best describes how the person thinks about themselves?							
Other (please describe how the client identifies, identifies as female and transgender)							
Ethnic origin: Which option best describes the persons ethnic group or background							
If other please specify							
Religion/belief: Which group does the person most identify with?							

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 <i>(please cross box that applies):</i>			
* Serious medical treatment , please indicate below treatment being referred for.			
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			
* 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.			
*Safeguarding Adults proceedings If yes, please state whether the client referred is: Please select one: 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.			
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						
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)						
Issue that independent advocacy is required for <i>(we can only accept referrals for adults for the issues below):</i>						
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



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