**IMCA Referral Form**



**Advocacy for All**

**The Civic Centre**

**St Mary’s Road**

**Swanley**

**BR8 7BU**

**Tel: 0345 310 1812**

**Email: referrals@advocacyforall.org.uk**

**Web: www.advocacyforall.org.uk**

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| **If you cannot complete this form, then please click view then edit.**  **Complete one form PER DECISION**  **Once completed please email to:** [**referrals@advocacyforall.org.uk**](mailto:referrals@advocacyforall.org.uk?subject=Care%20Act%20Advocacy%20Referral) |
| **BEFORE COMPLETING THIS FORM, PLEASE ANSWER THE FOLLOWING:**   * Are there any family and friends, or is there anyone (other than paid workers) who are considered willing and appropriate to be consulted about the decision? YES  NO  **If yes, you must state below why family or friends are not available or appropriate:**   Click or tap here to enter text.   * Has the person been assessed to lack capacity to make a particular decision? YES  NO  If yes, who carried out the test, when was it carried out and where are the notes are held:   Click or tap here to enter text.   * Identify the **decision maker** eg: the person responsible for making the final decision. Usually it is the Consultant/GP for serious medical treatment or the Care Manager for change of accommodation. The decision maker must give permission for this referral to be put forward.   **COMPLETING THE FORM:**   * Type your answers onto the shaded areas which expand as you type. * In each section choose ONE ANSWER ONLY. * More details can be entered under **any other relevant information.** |
| **Following receipt of referral, first contact with the referred person will be made within 3 working days of the referral.** |

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| **Referrer’s Name:** Click or tap here to enter text.  Relationship to client: 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.  Tel: Click or tap here to enter text. Mobile: Click or tap here to enter text.  Email: Click or tap here to enter text.  Funding Authority: Click or tap here to enter text. | **Client Title:** Click or tap here to enter text.  Client name: Click or tap here to enter text.  Reference number: Click or tap here to enter text.  Date of birth: Click or tap here to enter text.  Man  Woman  Transgender  Non Binary  Intersex  Prefer not to say  Your own term:…………………..  Address of clients **current** location : Click or tap here to enter text.  Postcode: Click or tap here to enter text.  Tel: Click or tap here to enter text.  **Please specify location type**: Own Home  Residential Home  Nursing Home  Supported Living  Other  Click or tap here to enter text.  Is this a first referral? YES  NO |
| Is the referrer the decision maker? YES  NO  If no, is the decision maker aware of this referral? YES  NO | |
| **Decision Maker 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.  Tel: Click or tap here to enter text. Ext/bleep: Click or tap here to enter text.  Mobile: Click or tap here to enter text.  Email: Click or tap here to enter text. | |

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| **Nature of client’s impairment:**  Choose an item.  If other, please specify:  Click or tap here to enter text. |  | | **Secondary Issue:**  Choose an item.  If other, please specify:  Click or tap here to enter text. |
| **Primary means of communication:**  English  Other spoken language  British sign language  Words/pictures/Makaton  Gestures/facial expressions/vocalisations | | **Ethnicity:** Choose an item. Other– please specify: Click or tap here to enter text. | |
| **Religion:** Choose an item.  Other– please specify: Click or tap here to enter text. | |
| **Sexuality:** Choose an item.  Other– please specify: Click or tap here to enter text. | |

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| **Date of referral:** Click or tap here to enter text. **Date of proposed action:** Click or tap here to enter text. | | |
| **Serious Medical Treatment:**    **What is the decision to be made?** Click or tap here to enter text. | | **Change of Accommodation :**  From: Click or tap here to enter text.  To: Click or tap here to enter text. |
| **Care Review:**  If yes, please state details and indicate how long the client has resided at the current location:  Click or tap here to enter text. | **Safeguarding:**  If yes, please state whether the client referred is:    **Please select one:** Choose an item.  **If other, please give details:** Click or tap here to enter text.  **What are the protective measures?:** Click or tap here to enter text. | |
| **Please state whether there are any planned meetings taking place and/or any other relevant information:** Click or tap here to enter text. | | |

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| **Does the client have an attorney, receiver or guardian?**  YES  NO  Please give name & telephone number and clarify the issue that they are dealing with:  **Has the client issued an advance decision?** YES  NO  If yes where is this held? Please give name and telephone number (usually medical or social care records):  **Are you aware of any other forms of record of the client’s wishes?**  YES  NO  If yes, in what form are they held, who holds them and where are they held. Name and telephone number needed:  **Does the IMCA need to be aware of any risks, hazards or infections when dealing with this case?** YES  NO  Please give details: Click or tap here to enter text. |

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| **The referrer’s agreement:**  If the person being referred is not able to give consent, I confirm that I am satisfied that it is in the person’s best interests to be supported and represented by an Independent Advocate.  I understand that the information I provide about the person will be stored securely on a computer. |

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| **Advocacy for All is an independent advocacy organisation Charity no: 1064855 Company no: 3407428** |

