Independent Advocacy
IMCA Referral Form

Client Name:						
Date of Birth:						
Date of Referral:						
Gender	**Female**		**Male**		**Other**	
Home address postcode Telephone						
Present location (if different from above) If in hospital please include ward number and **contact telephone number**.						

How does the person communicate?
What is their first language?

Sexual Orientation: Which of the following options best describes you/ the referee? (please cross box that applies)

Heterosexual/straight		Bisexual	
Homosexual		Prefer not to say	
Not known		Other (please describe):	

Religion/belief: Which group do you / the referee most identify with? (Please cross box that applies)

Buddhist		Jewish	
Christian		Muslim	
Hindu		Sikh	
No religion		Prefer not to say	
In another way (please describe):			

Ethnic origin: Choose one option which best describes you / the referee's ethnic group or background (please cross box that applies). Categories based on Census 2011 categories

Asian British/Bangladeshi		White British	
Asian British/Indian		White Irish	
Asian British/Pakistani		White Gypsy/Traveller	
Asian British/Chinese		Other White background (please describe):	
Any other Asian background (please describe):		Mixed Asian and White	
Black British/Black African		Mixed Black African and White	
Black British/Black Caribbean		Mixed Black Caribbean and White	
Any other Black/African/Caribbean background (please describe)		Any other Mixed/multiple ethnic background (please describe):	
Any other Ethnic group (please describe):		Prefer not to say/Not known/Not given	

Country of origin/cultural identity: How do you describe you / the referee's country of origin/cultural identity?

Do you consider yourself to have a disability?					
YES		**NO**		**Prefer not to say**	
If yes please tell us about the nature of your disability:					

Reason for Referral (please tick)

Serious Medical Treatment	
Move to accommodation (NHS body)	
Move to accommodation (Local Authority)	
Safeguarding Vulnerable Adults Procedure (LA)	
Care Review (NHS or LA)	

State Specific Decision (Proposed Options)

Others involved

Any family or friends	Yes/No
If yes, but they are inappropriate to consult please explain briefly why this is the case.	

Significant Dates

When does the decision need to be made by?	
Please give details of any impending meetings or deadlines.	

Has a capacity assessment been completed?	Yes/No
If so who completed this and on what date was it completed? (Please give name and designation e.g. Social Worker or Consultant)	
Is the person under a Deprivation of Liberty order?	Yes/No

Contact Details

Details of Person completing this form	Who will make the best interest decision?
Name:	Name:
Job Title:	Job Title:
Organisation:	Organisation:
Address:	Address:
Telephone: Direct Line: Mobile:	Telephone: Mobile:
Email:	Email:
Fax no:	

Please detail any risk issues or incidents we should be aware of:

I confirm that I have consent from the client to make a referral to Advocacy or	
I confirm I have the authority to make a referral for the client.	
I understand and agree that the information I provide will be stored securely and used for monitoring purposes. Any identifiable information is kept confidential and secure.	
I understand by ticking these boxes I confirm my agreement	

I am instructing the IMCA service to do this work. I am authorised by the NHS organisation or Local Authority responsible for making the decision.	
Signed:	Date:
Name (please print):	Relationship to client:

*Please continue on a separate sheet if necessary

Please return completed form to –

Independent Advocacy North East, Room B14 Linskill Centre, Linskill Terrace,
North Shields, Tyne and Wear NE30 2AY

Tel. (0191) 259 6662 E-mail: info@iane.org.uk
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