IMHA Referral Form

Not providing the necessary information could affect response times. Please complete the form in full.								
CLIENT DETAILS:								
Name:								
DOB:								
Gender:	M		**F**		**O**		**prefer not to say**	
Permanent Address:								
	Postcode:							
Current Location:								
	Postcode:							
	Telephone Number:							

ETHNIC BACKGROUND *(Please tick box that applies)*			
White British		Black \ Black British (African)	
White Irish		Black \ Black British (Caribbean)	
White (Other Background)		Black \ Black British (Other Background)	
Mixed: White \ Black African		Asian \ Asian British (Bangladeshi)	
Mixed: White \ Black Caribbean		Asian \ Asian British (Indian)	
Mixed: White \ Asian		Asian \ Asian British (Pakistani)	
Mixed: (Other Background)		Asian \ Asian British (Other Background)	
Chinese		Other Ethnic Group	
Any identified religious, cultural or spiritual needs?			

Sexual orientation: Which of the following options best describes how you / the referee think of yourself (*please cross box that applies***)**			
Heterosexual/straight		Bisexual	
Homosexual		Prefer not to say	
Not Known		Other (please describe):	

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

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):			

QUALIFYING PATIENTS FOR IMHA – DETAINED PATIENTS:				
Is the person detained under the Mental Health Act?	**YES**		**NO**	
Is the person subject to Supervised Community Treatment (SCT)?	**YES**		**NO**	
Is the person subject to guardianship?	**YES**		**NO**	
Please state which section of Mental Health Act:				
Date of Section:				
QUALIFYING PATIENTS FOR IMHA – INFORMAL PATIENTS				
Is the patient Informal and discussing the possibility of being given section 57 treatment?	**YES**		**NO**	
Is the patient under 18 and being considered for electro-convulsive therapy (ECT)?	**YES**		**NO**	

Please note that persons under short term and/or emergency detentions such as those made under Sections 4, 5(2), 5(4), 135 or 136 are not eligible for the IMHA service.

Please ensure the referral form is signed before returning

BRIEF DETAILS OF THE SITUATION THAT REQUIRES IMHA INVOLVEMENT
ARE THERE ANY DEADLINES OR IMPORTANT MEETING DATES?

IS THIS A SELF-REFERRAL?				
YES		**NO**		

The IMHA service has a duty to ensure the safety of lone workers. In accordance with the data protection act we reserve the right to speak to and request information from third parties regarding past and current risk. For further information please contact the IMHA service.

IF NO, PLEASE PROVIDE DETAILS BELOW						
Is this a first referral?		**YES**		**NO**		**NOT KNOWN**
Referrer Name:						
Position - Role:						
Address:						
Postcode:						
Telephone Number , Email and Fax:						
Name of Care Manager/Coordinator or Social Worker:						
Address:						
Postcode:						
Telephone Number , Email and Fax:						
Please provide name and contact details of GP:						
Is the current GP registration temporary? ***(i.e. due to hospital admission)***		**YES**		**NO**		
If yes please provide contact details of permanent GP:						

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Name of Responsible Clinician :	
Name of Nearest Relative:	

Has the patient been informed a referral is being made to the IMHA service?	**YES**		**NO**	
Has the patient consented to the referral to the IMHA service?	**YES**		**NO**	
Does the patient have capacity to instruct an IMHA?	**YES**		**NO**	

If you have answered NO to any of the above questions please explain, providing details of any capacity assessment:		

Is there any risk of violent or dangerous behaviour, or any other pertinent risks the IMHA should be aware of? (i.e. security issues, exposure to infection such as MRSA)	**YES**	
	NO	

If yes, please explain, including any risk assessments i.e. FACE:	

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	

Because of the Date Protection Act a signature is needed to say that you agree to the IMHA Service securely holding personal information (including the information on this form), on a computer and in a filing system. It is the policy of the IMHA service 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. The IMHA service is a confidential service; you can request further information on confidentiality from the appropriate IMHA service.

I agree to that the IMHA service can securely hold, and put on computer and in a filing system, the information on this form.

_____ _____

SIGNATURE **DATE**

THE REFERRER (leave blank if signed by client) I would like the IMHA to do this work. They can keep, and put on computer and in a filing system, the information on this form provided to do the work. I am providing this information and asking for this referral in the client's best interests.

_____ _____

SIGNATURE **DATE**

_____

PRINT NAME

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PLEASE NOTE	
When deciding which service to contact, please note the IMHA service provision is based on residency. Please refer to the service where the person is currently residing ie hospital area and not where their permanent address is.	
PLEASE RETURN THE COMPLETED FORM TO THE RELEVANT IMHA SERVICE.	
North Tyneside Independent Advocacy North East Room B14 Linskill Centre Linskill Terrace North Shields Tyne and Wear NE30 2AY T: 0191 259 6662 Email: info@iane.org.uk www.iane.org.uk	**Northumberland** Adapt (North East) Burn Lane, Hexham, Northumberland, NE46 3HN Tel: 01434 600599 Fax: 01434 605251 www.adapt-ne.org.uk Email: generaloffice@adapt-tynedale.org.uk
Gateshead Connected Voice Advocacy Higham House, Third Floor, Newcastle upon Tyne NE1 8AF T: 0191 2327445 F: 0191 230 5540 Email: connect@connectedvoice.org.uk www.connectedvoice.org.uk	**Sunderland** VoiceAbility Address: 1d North Sands Business Centre Liberty Way Sunderland SR6 0QA Tel: 0191 917 9964/0300 303 1660 Email: helpline@voiceability.org
Newcastle and South Tyneside Your Voice Counts The Old Bank, Nelson Street Gateshead NE8 1AX T:0191 478 6472 F:0191 477 8559 Email:yvc.uk@nhs.net www.yvc.org.uk	