**Independent Mental Health Advocate (IMHA) Referral Form**

Referral date: ……………………. Received date: …………………

**CLIENT DETAILS**

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  | Gender *(Please tick)* | F |  | M |  |
| Permanent Address |  |
| Post code |  |
| Current Location |  |
| Post code |  |
| Telephone number |  |
| Does the client have **any** disabilities? |  |

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| **Client Ethnic Background** |
| White British |  | White Irish |  | White Gypsy / Irish Traveller |  |
| Other White background |  | Mixed / Multiple Ethnic Groups: White & Black Caribbean |  | Mixed / Multiple Ethnic Groups: White & Asian |  |
| Mixed / Multiple Ethnic Groups: White & Black African |  | Mixed / Multiple Ethnic Groups: other  |  | Asian / Asian British: Indian |  |
| Asian / Asian British: Pakistani |  | Asian / Asian British: Bangladeshi |  | Asian / Asian British: Chinese |  |
| Asian / Asian British: other |  | Black / African / Caribbean / Black British: African |  | Black / African / Caribbean / Black British: Caribbean |  |
| Black / African / Caribbean / Black British: other |  | Other Ethnic Group: Arab |  | Other Ethnic Group: other |  |
| Any identified religious, cultural or spiritual needs? |  |

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| **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 the Mental Health Act: |  |
| Date of section: |  |

**QUALIFYING FOR AN IMHA**

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| **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.*  |

**RISK ASSESSMENTS**

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| Please tick the box where the client has shown signs of risk. Please include copies of up-to-date risk assessments, i.e. FACE, when submitting the referral |
| Suicide tendencies |  | Lack of insight |  |
| Deliberate self-harm |  | Hostage taking |  |
| Self-neglect |  | Housing problems |  |
| Physical aggression without a weapon |  | Drug and alcohol misuse |  |
| Physical aggression with a weapon |  | Misuse of medication |  |
| Violent behaviour |  | Physical Health |  |
| Verbal aggression |  | Social Isolation |  |
| Criminal record |  | Lack of family support |  |
| Offending behaviour |  | Harassment/bullying (safeguarding) |  |
| Child protection issues |  | Risk to service user |  |
| Inappropriate behaviour (describe below) |  | Financial difficulties |  |
| Arson |  | Relationship difficulties |  |
| Non-compliance with care plan |  | Other – Please specify below |  |
| Please explain risks and include copies of assessments: |

**IMHA INVOLVEMENT**

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| Please include brief details of the situation that requires IMHA involvement: |
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| Are there any deadlines or important meeting dates? |
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**REFERRAL DETAILS**

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| Is this a self-referral? *(please tick)* |
| 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.  |

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| If this is not a self-referral please fill in details below: |
| Is this a first referral?*(Please tick)* | YES |  | NO |  | NOT KNOWN |  |
| Referrer Name |  |
| Position/Role |  |
| Address |  |
| Postcode |  |
| Telephone, Email and Fax number |  |
| Name of Care Manager/Coordinator or Social worker |  |
| Address |  |
| Postcode |  |
| Telephone, Email and Fax number |  |

|  |  |
| --- | --- |
| 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 these questions, please explain why, providing details of any capacity assessment |  |

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| **Because of the Data Protection Act, a signature is required to say that you agree to the Northumberland Independent Advocacy service holding personal information, (including this form), on a secure electronic case management system, a computer, and in a paper filing system. It is the policy of the Adapt (North East) Advocacy Service that all personal data will be held in accordance with the principles and requirements of the General Data Protection Regulations and other relevant legislation, and that procedures will be put in place to ensure fair processing of data relating to individuals. Northumberland Independent Advocacy service is a free and confidential service. You can request further information on our Privacy and Confidentiality policies by contacting our main office. Please find contact details below.** |

**The client**:*I agree that the information on this form can be securely stored by Adapt (North East) Advocacy service on a secure electronic case recording system, computer and paper filing system.*

CLIENT SIGNATURE PRINT NAME DATE

**The referrer**: *I would like an IMHA to do this work. They can keep this information stored on a secure electronic case recording system, computer and paper filing system. I am providing this information and asking for this referral in the client’s best interest.*

REFERRER SIGNATURE PRINT NAME DATE

**PLEASE RETURN THIS FORM TO:**

advocacy@adapt-tynedale.org.uk - please ensure documents are sent securely to this address **OR** Secure email: advocacy@adapt-tynedale.cjsm.net – only use this address if sending from a CJSM account.

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Northumberland Independent Advocacy Service, Adapt (North East),

Burn Lane, Hexham, Northumberland, NE46 3HN

**Tel:** 01434 600599 **Fax:** 01434 605251