**Independent Mental Health (IMHA) and Informal Inpatient Referral**

**This form can be used by professionals or nearest relatives to refer both Qualifying IMHA Patients and Informal Inpatients. Alternatively, referrals can be made by telephone on 0330 440 9000.**

**Patients may also refer themselves directly to the advocacy service.**

***If completing online, click once on relevant box to check. Write in text fields, where required.***

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| **Date of Referral:** | | | | | |
| **Professional Referrer’s Details** | | | | | |
| **Referrer First Name:** | | | | **Last Name:** | |
| **Organisation:** | | | | | |
| **Job Title or Relationship to Patient:** | | | | | |
| Doctor | | Psychiatrist | | | Ward Manager |
| Care Manager | | Care Home Manager | | | Team Manager Health |
| Nurse / Health Professional | | Social Worker (Hospital) | | | Social Worker (Community) |
| Team Manager Social Care | | Administrator | | |  |
| Other / Non-Professional Relationship (specify) | | | | | |
| **Address:** |  | | | | |
| **Postcode:** | | | | | |
| **Tel No:** | | | **Mobile No:** | | |
| **Email:** | | | | | |

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| **Main Disability** Is there a **main** disability or impairment considered particularly relevant to this case? | | |
| Check **ONE** box only | | |
| Mental Health Problem  Physical Disability  Sensory (Hearing)  Sensory (Sight) | Asperger’s /Autism Spectrum Condition  Cognitive Impairment  Acquired Brain Injury  Serious Physical Illness | Learning Disability  Dementia / Alzheimer’s  Unconsciousness  **NO** |

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| **Patient Information** | | | | |
| **Title:**  Mr  Mrs  Ms  Other | | **First Name:**  **Last Name:** | | |
| **Date of Birth:** | | | | |
| **Permanent Address:** |  | | | |
| **Postcode:** | | | | |
| **Telephone No.** | | | **Mobile No.** | |
| **E-mail** | | | | |
| **Preferred method of contact:** | | | | |
| Any  Telephone  E-mail  Post  Mobile Phone  Text  Cannot be contacted directly | | | | |
| **Does the patient consider themselves to have a disability?**  **Does the Client consider themself to have a disability?** | | | | |
| Yes  Not known | | | | No  Prefers not to say |
| **What types of disability or impairment does the patient have?** Select **ALL** that apply | | | | |
| Mental Health Problem  Physical Disability  Sensory (Hearing)  Sensory (Sight)  Asperger's / Autism Spectrum Condition  Cognitive Impairment | | | | Acquired Brain Injury  Serious Physical Illness  Learning Disability  Dementia / Alzheimer’s  Unconsciousness  Other (specify) |
| **What is the patient’s primary communication method?**  Spoken English  Other Spoken Language (specify)  British Sign Language (BSL)  Other (specify)  Words/Pictures/Makaton  No obvious means of communication  Gestures/Facial Expressions/Vocalisations Not known | | | | |
| **Is English Spoken?**  Yes  No | | | | |

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| **Patient Location Details** | |
| **Patient’s current location:**  Own Home  Dementia Ward  Hospital  Own Home with Support  Care / Nursing home  Homeless  Supported Living  Prison  No Fixed Abode  Acute Psychiatric Unit  Forensic Secure Unit  Other Institution | |
| **Is patient currently at their permanent address?**  Yes  No (If No, give details below) | |
| **Current Address:** |  |
| **Postcode:** | |
| **Telephone No.** | |
| **Ward Name (if in Hospital):** | |
| **Advocacy Referral Details** | |
| **Qualifying Patients:** This includes detained patients (excluding those subject to sections 4, 5(2), 5(4), 135 and 136), even if they are on leave or conditionally discharged. This also includes patients on s.17A Community Treatment Orders, s.7 Guardianship and informal patients under 18 who are being considered for ECT (for full eligibility, see Chapter 6 of the Mental Health Act 1983, Code of Practice). Patients with capacity must either consent to the referral OR the Responsible Clinician, AMHP or Nearest Relative believe that the patient might benefit from IMHA support but are unable or unlikely, for whatever reason, to request this for themself. All patients who lack capacity to decide whether or not to obtain help from an IMHA must be referred to the service. | |
| **The Patient is a Qualifying Patient**  Yes | |
| **To which section of the MHA is the patient subject (if known)?**  **Is patient subject to any further (i) section of the MHA (if known)?**  **Is patient subject to any further (ii) section of the MHA (if known)?** | |
|  | |
| **Informal Inpatients:** Although informal inpatients and those detained on short term / emergency sections do not have a legal right to an IMHA, an advocate may be able to provide advocacy on an informal basis, subject to availability. | |
| **The Patient is an Informal Inpatient**  Yes | |
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| **Is the patient subject to Section 117 Aftercare?**  Yes  No  Don’t know | |
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| **Has the patient consented to this referral?**  Yes  No | |

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| **Name of Responsible Clinician / Consultant Psychiatrist:** |
| **Date of Detention (if applicable):** |

**What is the issue / situation requiring an advocate?**

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| **Is the patient subject to seclusion?**  Yes  No |

**Are there any deadlines or important meeting dates?**

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**Are there any risk factors of which the advocate should be aware?**

If you are not aware of any risks, please write 'no known risks'

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| **Does the patient have capacity to request / decline an advocate?**  Yes  No | | |
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| **Permission to Share:**  Can an advocate be contacted in the event of discharge into Guardianship or Community Treatment Order? | Yes  No | |

**Declaration:**

* I would like to instruct an IMHA.
* I am providing this information and making this referral in relation to the Mental Health Act 1983.
* In accordance with current Data Protection legislation, I agree to The Advocacy People and their delivery partners holding personal information (including information on this form).
* I understand the provision of an advocacy service is subject to the patient meeting eligibility criteria.

**Please e-mail the completed form to** [info@theadvocacypeople.org.uk](mailto:info@theadvocacypeople.org.uk)

or post to P.O. Box 375, Hastings TN34 9HU

If you have not received confirmation of this referral within 2 working days, or you would like to discuss any aspects of a referral, please call **0330 440 9000**

By requesting advocacy support, you give consent to The Advocacy People sharing information, as required for the purposes of providing the service. For more information on our Privacy Policy, please ask your advocate or go to [www.theadvocacypeople.org.uk/privacy](http://www.theadvocacypeople.org.uk/privacy)

**Confidentiality:**

Communications between you and The Advocacy People are confidential. We will not divulge any information without your permission unless disclosure is required or permitted by law, e.g. where you tell us something which leads us to believe you or someone else may be at risk of serious harm or abuse or committing a serious criminal offence, where there is a court order for disclosure, or where we would be breaking the law by failing to disclose.

All records are held by The Advocacy People in accordance with current Data Protection legislation.