Derbyshire Independent
Mental Capacity Advocacy Service
IMCA

Office use only
Date Referral received
…………………………

Referral Form

Please complete all details and post to: Sarah Marchbank (Derbyshire IMCA Service Manager), c/o Derbyshire Mind Advocacy Service, Kingsway Hospital, Derby, DE22 3LZ or email to enquiries@derbyshireimca.org.uk or fax to 01332 293884

If you have any questions regarding the completion of this form please contact the IMCA Referral line on 01332 380224

Please note: it is permissible for a third party to send the referral form prior to the decision maker's confirmation being obtained. This will ensure the client does not experience a delay in gaining the services of an IMCA.

The decision maker's signed authorisation must follow within 5 working days or the IMCA will be unable to proceed and the referral information will be returned.

Monitoring Information

We are required by the Department of Health to provide detailed monitoring information for each IMCA referral. Please ensure that the following is completed:

Gender Ethnic Background

Male		White		Black or Black British		Mixed White		Asian or Asian British		Chinese or other ethnic group	
Female		British		Black Caribbean		White & Black Caribbean		Indian		Chinese	
		Irish		Black African		White & Black African		Pakistani		Other ethnic category (specify)	
		Other(specify White)		Other Black (specify)		White & Asian		Bangladeshi			
						Other Mixed White (specify)		Other Asian (specify)			

Primary Communication

Spoken English		Another spoken language		Gestures/facial expression/vocalisations		Other
BSL		No obvious communication		Pictures/symbols/makaton		

Does the client have a disability?

Mental Health Problems		Learning Disability		Other general needs (please state)
Serious Physical Illness		No/Not known		

Nature of client's impairment

Unconsciousness		Mental Health Problems		Acquired brain damage		Learning Disability		Combination	
Autism Spectrum Condition		Serious Physical Illness		Dementia		Cognitive Impairment		Other (please state)	

Referral Information

Name of Client:		Date of birth:
Current address		
Home address		
Telephone Number:		
Local Authority: (please circle)		

Name of Decision Maker:	
Address:	
Telephone Number(s):	

Relationship to client

GP		Social Worker		Other (please state)
Hospital Doctor		Care Manager		

Nature of decision:

Serious Medical Treatment		Long – Term Care Move	
Adult Protection Case		Care Review	

Please provide brief details of circumstances of the decision and the decision makers recommended course of action and any meeting dates/deadlines:

Has the client been referred to the IMCA service previously?

Yes ☐ No ☐

Does the client have family/friends who are appropriate and willing to be consulted with about this decision? Yes ☐ No ☐

Name of refer: (if not decision maker)	
Address:	
Telephone number(s):	

<u>Other relevant people for IMCA to contact:</u>
E.g., GP, care home staff, neighbour (continue on separate sheet if necessary).

Name	Name
Relationship to client	Relationship to client
Address:	Address:
Telephone number(s)	Telephone number(s)

Are there any foreseeable risks to meeting with client in a one to one setting?

Signed………………………… Date……………………………………...

Name……………………………………………………………………………………….

Decision Makers Authorisation Form

The decision maker is the individual within either the Local Authority or NHS who is responsible for the decision in question.

<u>Only the decision maker is able to confirm the following:</u>

* I confirm that I am the decision maker on behalf of
Derbyshire PCT/LA, Derby PCT/LA (Delete as appropriate)

…………………………………………………………………………………………...

for the decision in question regarding (*client name*)

…………………………………………………………………………………………...

* I also confirm that I deem the client named above to be unbefriended, with no-one appropriate to consult regarding this issue.

* I also confirm that the client named above has been assessed as lacking capacity to make a decision regarding this issue.

Signed ……………………………………………. Date …………………………………

Name …………………………………………….. Designation …………………………

Contact Details ……………………………………..
……………………………………..
……………………………………..
……………………………………..
……………………………………..

Please return this form to: Sarah Marchbank, Derbyshire IMCA Service Manager, c/o Kingsway Hospital, Derby DE22 3LZ.
Fax: 01332 293884 Email: enquiries@derbyshireimca.org.uk

<u>PLEASE NOTE</u>

Your signed authorisation is required within 5 working days in order for the referral to proceed.