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**Independent Advocacy**

**IMCA Referral Form**

***Please send a copy of the Mental Capacity Act assessment relevant to the decision to be made***

|  |  |
| --- | --- |
| Client Name: |  |
| Date of Birth: |  |
| Date of Referral: |  |
| Gender | **Female** |  | **Male** |  | **Other** |  |
| Home addresspostcodeTelephone  |  |
| 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? |

|  |
| --- |
| **Does the person have a disability?** |
| **YES** |  | **NO** |  | **Prefer not to say** |  |
| **If yes please tell us about the nature of their disability:** |
|  |

**Reason for Referral (please tick)**

|  |  |
| --- | --- |
| Serious Medical Treatment  |  |
| Move to accommodation (NHS body) |  |
| Move to accommodation (Local Authority)  |  |
| Safeguarding Vulnerable Adults Procedure (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 |  |

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

|  |  |
| --- | --- |
| 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: |  |

**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?**

|  |
| --- |
|  |

|  |  |
| --- | --- |
| 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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**What is an IMCA?**

An Independent Mental Capacity Advocate (IMCA) is a trained and experienced  advocate who can be instructed when an individual is deemed to lack capacity to make certain significant decisions, and at such time has no ‘appropriate’ family or friends to support them.

• The IMCA service is a safeguard under the Mental Capacity Act

• An IMCA is independent of the decision maker.

The IMCA role is there to support and represent the person during the  decision-making process, making sure that the Mental Capacity Act is being used correctly.  An IMCA may formally challenge the  decision-making process.

**When should an IMCA be involved?**

An IMCA must be involved if there are no ’appropriate’ family or friends to consult where the person is deemed to lack capacity to make the decision about:

1. The giving, withholding or withdrawal of serious medical treatment

2. A proposed move into nursing or residential care for longer than a period of eight weeks, or a move into a hospital for more than 28 days

3 Any change of residence

4. IMCAs must be instructed for people who are being assessed as to whether they are currently being, or should be, deprived of their liberty where there is no-one ‘appropriate to consult’.

IMCA’s may be instructed ( as a discretionary part of the act) on behalf of a person lacking capacity in relation to:

1. Care Review

2. Safeguarding referrals (irrespective of family or friend involvement)

3. Accommodation (This needs to be deleted as is a statutory duty)

4. Serious Medical Issue. (This needs to be deleted as is a statutory duty)

**What is an IMCA?**

An IMCA will:

1. Try to support and represent the person lacking capacity, presenting their views and interests to the decision maker.

2. Seek the views of professionals involved and review relevant social and medical records.

3. Review the decision in line with the Mental Capacity Act and its associated Codes of Practice.

4. Prepare a report that must be taken into account by the decision maker.

**An IMCA does not:**

1. Assess a person’s capacity

2. Make the decision

3. Decide who is ‘appropriate’ to consult

4. Provide on–going advocacy support.

The decision-maker must decide if a person meets the criteria for referral to an IMCA following guidance in the Code of Practice.

The decision-maker will be a professional who will ultimately action the decision.

**Independent Mental Capacity Advocacy (IMCA)**

The IMCA service is a safeguard under the Mental Capacity Act for people deemed to lack the capacity to make specific important decisions. The IMCA role supports and represents the person during the decision-making process, making sure that the Mental Capacity Act is correctly used. An IMCA’s role and functions can be quite specific under the Act, but IMCAs are always required to produce a report for the person who instructed them. This report is provided to the decision maker and those who instruct IMCAs must pay attention to any issues raised by the IMCA in making their decision and IMCAs may formally challenge their decision-making.

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