



voice | action | change

# IMCA REFERRAL FORM

*(This page will be used as case file front sheet when a referral is actioned)*

**Date referral received (office use only):**

**Case No (office use only):**

**PLEASE COMPLETE PAGES 1, 2 and 3**

**NAME OF PERSON REFERRED:**

**DOB:**

**Sex: M / F**

**Ethnicity (see separate info):**

**Client's diagnosis:**

**Address:**

**Tel No:**

**Where is the person NOW?**

**Decision-maker (on referral issue):**

**Position:**

**Organisation:**

**Contact details: Tel No:**

**email:**

**Referrer (if different from decision-maker):**

**Position:**

**Organisation:**

**Contact details: Tel No:**

**email:**

**Hospital & Ward:**  
*(if applicable)*

**Admission date:**

**Involved professionals not listed above and contact details:**

**Client's language/preferred communication methods:**

**RISKS TO PERSONAL SAFETY – Detail any information needed to ensure the safety of the advocate and the referred person, including risk management procedures in place:**

**IMCA REFERRAL FORM**

<b>PERSON REFERRED:</b>									
Referrer's relationship to referred person:									
<p><b>CAPACITY:</b></p> <p>* Name &amp; position of the professional who has decided the referred person lacks mental capacity to make a decision on the referral issue:</p> <p>* Please confirm that the <u>2 stage functional assessment of capacity</u> has been carried out:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 20%;">Is referred person:</td> <td style="width: 60%;">Aware of the advocacy referral?</td> <td style="width: 20%; text-align: right;">Y / N</td> </tr> <tr> <td></td> <td>Able to make some decisions without support?</td> <td style="text-align: right;">Y / N</td> </tr> <tr> <td></td> <td>Able to make his/her wishes known on the referral issue?</td> <td style="text-align: right;">Y / N</td> </tr> </table>	Is referred person:	Aware of the advocacy referral?	Y / N		Able to make some decisions without support?	Y / N		Able to make his/her wishes known on the referral issue?	Y / N
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	Able to make some decisions without support?	Y / N							
	Able to make his/her wishes known on the referral issue?	Y / N							
<p><b>FAMILY &amp; FRIENDS:</b></p> <p>* Does the referred person have family? Y / N      and/or      friends? Y / N</p> <p>* If yes, outline the nature of their involvement:</p> <p>* If the decision-maker does not consider them appropriate to consult with, give reasons why: <u>Please use the guidance on 'Who is appropriate' and select relevant criteria (this does not apply in Adult Safeguarding/Protection)</u></p>   <p>* <u>These are mandatory questions which must be fully completed</u></p>									

**IMCA REFERRAL FORM**

**PERSON REFERRED:**

**WHAT IS THE BEST INTEREST DECISION?**

- Serious Medical Treatment  Long term accommodation   
Adult Protection  Care Review

**DATE DECISION NEEDS TO BE MADE BY:**

If Adult Protection/Safeguarding: Please give the date of the Strategy Meeting or Case Conference if known:

**REASON FOR REFERRAL:**

Please refer to 'Guidelines for Referral' and detail the decision to be made:

If the referral is for Adult Protection/Safeguarding please outline the safeguarding issues.

Signature: \_\_\_\_\_ (Referrer)

Signature: \_\_\_\_\_ (Decision maker)

**PLEASE NOTE that if you are signing as a referrer but you are not the decision maker in this case, a signature will be required from the decision maker. The case cannot proceed if the decision maker has not signed the referral form**

Date: \_\_\_\_\_

I instruct an IMCA to be involved in the client's care review following a change of accommodation decision.

Signature \_\_\_\_\_ (Decision maker)

Date \_\_\_\_\_

**PLEASE RETURN TO: IMCA, 1a FORTESCUE ROAD, CAMBRIDGE CB4 2JS**  
**IMCA FAX: 0871 714 2707 or [imca@speakingup.org](mailto:imca@speakingup.org)**