

IMCA SERVICES REFERRAL FORM

Bath Mind IMCA service provides an Independent Mental Capacity Advocate to represent and support people who meet all the following criteria;

1. The person referred lacks capacity to make a decision concerning:
 1. serious medical treatment or
 2. long term care and health moves (more than 28 days in hospital /8 weeks in a care home), **or**
 3. care reviews, and they have no appropriate family or friends to represent them

2. The person referred is subject to an adult protection case, whether or not appropriate family, friends or others are involved

Referral Information [please circle (or highlight if using email,) where there are options]

Name of client /name usually known by		Date of birth	
Address		Gender	
		Religion	
		Postcode	

White British	White Irish	Black Caribbean	White/black Caribbean	White/Asian	Bangladeshi	Indian	Chinese
Other white background	Black African	Other black background	White/black African	Other mixed background	Pakistani	Other Asian background	Other Ethnic group

Primary communication	English	Another spoken language	Gestures/vocalisations/facial expressions
Pictures/symbols/Makaton	BSL	other	No obvious communication

What is the understanding of the person's capacity to make this decision?	Lacks capacity to make this decision	For the foreseeable future	At this time
On what basis was the decision about the persons capacity made	Decision-maker's judgement	Assessment by another professional	Other

Client group/ reason for lacking capacity	Learning disability	Autistic Spectrum Disorder	Mental Health	Serious physical illness
	Dementia	Acquired brain injury	Unconscious	Other

What is the decision to be made about?	Accommodation	Serious Medical Treatment	Care Review	Adult Protection		
When does the decision need to be made by?						
When are any deadlines or important meeting dates?						
Where is the person currently staying?	Own home	Care/nursing home	General hospital	Psychiatric hospital	Uncertain	Other
What is the decision-maker's recommended cause of action?						

Are there any family/friends?	yes	no	uncertain
If there are family, friends etc., why is an IMCA needed?			
Names and contact details of anyone who may be able to indicate the person who lacks capacity's wishes e.g. care manager, Dr, manager of home, care staff, nurses, or any other significant person.			
Any other relevant information			

Name of referrer		Telephone	
Address			
Email		Mobile	
Is the referrer the decision maker?	YES		NO
If not, give the name and contact details of the decision maker	Name		Address and telephone number

Consent for referral

Because of the Data Protection Act 1998, we need signed authorisation to say that people agree to Bath Mind IMCA Service holding personal information (including the information on this form).

The person being referred is deemed to lack capacity, therefore, the referrer must sign to say they are referring and providing information in the person's best interests, acknowledging that the person referred lacks capacity to make this decision.

Consent from the referrer			
I am instructing Bath Mind IMCA Service to do this work. They can keep, and put on computer the information on this form, and other information I provide needed to do the work. I am providing this information and asking for this referral in the best interests of the person concerned.			
Signed		Date	

Please return this form to:

Email: bathmindimca@btconnect.com Telephone and Fax: 01225 316330

Bath Mind IMCA Service 13 Abbey Church Yard Bath BA1 1LY