**IMCA Referral Form**

To engage and provide support and representation for people who have been assessed to lack capacity and who have no-one else to support them when major potentially life changing decisions are being made.

Referrals must be made by the decision maker or someone authorised by them.

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| 1. **Eligibility.** | | | | | | | | | | | | | | | |
| **The person being referred must:**   1. *Be 16+.* 2. *Be staying at the time of instruction in the local authority area, regardless of the person’s ordinary residence/funding authority. Staying includes temporarily living within the local authorities or being an inpatient in a hospital in the area.* 3. *Be assessed as lacking capacity specifically in relation to the proposed decision.* 4. *Have no consultable family or friends.* 5. *Have no decision-making arrangements in place such as powers of attorney or advance decisions.* 6. *Be facing any of the following decisions:*  * ***Serious Medical Treatment – Duty to Instruct*** *(provision, withholding or withdrawal of treatment).* * ***Change of Accommodation – Duty to Instruct*** *(hospital stays of 28 days or more, care home stays for more than 8 weeks).* * ***Accommodation Review – Power to Instruct*** *(decision about current accommodation).* * ***Safeguarding of Vulnerable Adults – Power to Instruct*** *(irrespective of friends/family in relation to proposed protective measures).* | | | | | | | | | | | | | | | |
| 1. **About the person requiring support.** | | | | | | | | | | | | | | | |
| **Mr/ Mrs:** | | | **Name:** | | | | | | | | **Date of birth:** | | | | |
| **Tel:** | | | **Email:** | | | | | | | | **Mobile:** | | | | |
| **Current Address:**  **Postcode:** | | | | | | | | | | | | | | | |
| Own Home: | | Care Home: | | | | Hospital: | | | | Health Unit: | | | Other: | | |
| 1. **How does this person communicate?** | | | | | | | | | | | | | | | |
| Preferred Language: | | | | | | | | | Dialect: | | | | | | |
| Spoken Language | | | | | | | |  | Gestures/Facial Expressions/Vocalisations | | | | | |  |
| British Sign Language | | | | | | | |  | Words/ Pictures/ Makaton | | | | | |  |
| Not known | | | | | | | |  | Other, please give details: | | | | | | |
| **Known Risks (to themselves or others):** | | | | | | | | | | | | | | | |
| 1. **What are the person’s additional support needs?** | | | | | | | | | | | | | | | |
| Mental Health problems | | | | | | | |  | Physical Health | | | | | |  |
| Cognitive Impairment | | | | | | | |  | Autism Spectrum Condition | | | | | |  |
| Learning Disability | | | | | | | |  | Serious Physical Illness | | | | | |  |
| Dementia | | | | | | | |  | Acquired Brain Damage | | | | | |  |
| Unconsciousness | | | | | | | |  | Serious Physical Illness | | | | | |  |
| Other | | | | | | | |  | Please specify: | | | | | | |
| 1. **Decision type (for multiple issues please submit a referral for each one).** | | | | | | | | | | | | | | | |
| Serious Medical Treatment (provisions, withholding, withdrawal of treatment). | | | | | | | |  | Change of Accommodation (hospital stay of 28 days or more, nursing/residential stay of 8 weeks or more). | | | | | |  |
| Care Reviews  (reviews should relate to decisions about accommodation). | | | | | | | |  | Safeguarding Adults Investigation (irrespective of friends and family in relation to proposed protective measures). | | | | | |  |
| Please provide details of any proposed protective measures: | | | | | | | | | | | | | | | |
| 1. **Capacity.** | | | | | | | | | | | | | | | |
| Has the person been assessed to lack capacity? | | | | Yes | | | No | | What decision was this in relation to? | | | | | | |
| Who completed the assessment? | | | | | | | | | Date of assessment? | | | | | | |
| Please confirm there are no consultable family or friends. (If family are in disagreement they are still consultable). | | | | | | | | | | | | Yes | | No | |
| If family and friends are known but are not considered consultable, please state why: | | | | | | | | | | | | | | | |
| 1. **Decision details.** | | | | | | | | | | | | | | | |
| Please give details of the situation surrounding the decision, including any essential information and/or special instructions for contacting the person: | | | | | | | | | | | | | | | |
| Please give any meeting dates or decision details: (*Please provide dates/location/ time/ in person or via Teams. Are other professionals in attendance?)* | | | | | | | | | | | | | | | |
| 1. **Additional Information.** | | | | | | | | | | | | | | | |
| Please provide any information which will help the Advocate to support the person being referred.  What steps need to be taken to maximise the person’s full participation? *(Consider mental capacity, sensory needs, autism related needs and confidence, use of interpreters, appropriate adult, family members, information and advice, communication aid, appropriate time of day/effects of medication, suitable environment).* | | | | | | | | | | | | | | | |
| 1. **Diversity Monitoring.** | | | | | | | | | | | | | | | |
| **By completing the information below you can help us ensure our services reach everyone who needs them and inform how we might improve our service provision.** | | | | | | | | | | | | | | | |
| **What is the person’s gender?** | | | | | | | | | **Is the person’s gender different from that assigned at birth?** | | | | | | |
| Male | | | | |  | | | | Yes | | | | |  | |
| Female | | | | |  | | | | No | | | | |  | |
| Non-binary | | | | |  | | | | Don’t know/prefer not to say | | | | |  | |
| Don’t know/prefer not to say | | | | |  | | | |  | | | | |  | |
| Person’s own description: | | | | | | | | |  | | | | |  | |
| **What is the person’s sexual orientation?** | | | | | | | | | | | | | | | |
| Heterosexual/straight | | | | |  | | | | Gay woman/lesbian | | | | |  | |
| Bisexual | | | | |  | | | | Don’t know/prefer not to say | | | | |  | |
| Gay man | | | | |  | | | | Person’s own description: | | | | | | |
| **What is the person’s ethnic group?** | | | | | | | | | | | | | | | |
| *Asian or Asian British* | | | | | | | | | | | | | | | |
| Bangladeshi | | | | |  | | | | Pakistani | | | | |  | |
| Chinese | | | | |  | | | | Another Asian background | | | | |  | |
| Indian | | | | |  | | | | Don’t know/prefer not to say | | | | |  | |
| *Black, African, Black British or Caribbean* | | | | | | | | | | | | | | | |
| African | | | | |  | | | | Another black background | | | | |  | |
| Caribbean | | | | |  | | | | Don’t know/prefer not to say | | | | |  | |
| *Mixed or multiple ethnic groups* | | | | | | | | | | | | | | | |
| Asian and White | | | | |  | | | | Another Mixed background | | | | |  | |
| Black African and White | | | | |  | | | | Don’t know/prefer not to say | | | | |  | |
| Black Caribbean and White | | | | |  | | | |  | | | | |  | |
| *White* | | | | | | | | | | | | | | | |
| English/Welsh/Scottish/Northern Irish/British | | | | |  | | | | Another White background | | | | |  | |
| Irish | | | | |  | | | | Don’t know/prefer not to say | | | | |  | |
| Irish Traveller or Gypsy | | | | |  | | | |  | | | | |  | |
| *Another ethnic group* | | | | | | | | | | | | | | | |
| Arab | | | | |  | | | | Don’t know/prefer not to say | | | | |  | |
| Another ethnic background | | | | |  | | | | Person’s own description: | | | | | | |
| **What is the person’s religion?** | | | | | | | | | | | | | | | |
| No religion | | | | |  | | | | Hindu | | | | |  | |
| Christian (all denominations) | | | | |  | | | | Muslim | | | | |  | |
| Buddhist | | | | |  | | | | Other (please state) | | | | |  | |
| Jewish | | | | |  | | | | Don’t know/prefer not to say | | | | |  | |
| Sikh | | | | |  | | | | Person’s own description: | | | | | | |
| **Does the person identify as having a disability or long-term health condition?** | | | | | | | | | | | | | | | |
| Yes | No | | Please specify: | | | | | | | | | | | | |

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| 1. **Referral Contacts.** | | | | | | | | |
| **Person making the referral.** *(Authorised Officer).* | | | | | | | | |
| Consultant | |  | Social Care Team Manager | | |  | | |
| Doctor | |  | Social Worker | | |  | | |
| Other: | | | | | | | | |
| Name of referrer: | | | Job title: | | | | | |
| Team: | | | Organisation: | | | | | |
| Email: | | | Tel: | | | | | |
| Address: | | | | | | | | |
| Same contact details as the: | Client Contact | |  | Decision-maker | | | |  |
| **Person responsible for the best-interest decision.** *(Decision Maker).* | | | | | | | | |
| Consultant | |  | Social Care Team Manager | | |  | | |
| Doctor | |  | Social Worker | | |  | | |
| Other: | | | | | | | | |
| Name of referrer: | | | Job title: | | | | | |
| Team: | | | Organisation: | | | | | |
| Email: | | | Tel: | | | | | |
| Address: | | | | | | | | |
| Same contact details as the: | Client Contact | |  | Decision-maker | | | |  |
| **Person to contact to make visiting arrangements.** *(Client Contact).* | | | | | | | | |
| Name of referrer: | | | Tel: | | | | | |
| Address: | | | | | | | | |
| Same contact details as the: | Client Contact | |  | Decision-maker | | | |  |
| 1. **Consent.** | | | | | | | | |
| Have you discussed this referral with the person being referred? (where appropriate) | | | | | Yes | | No | |
| Has the person agreed to this referral being made? | | | | | Yes | | No | |
| **Disclaimer** | | | | | | | | |
| **Please note that we may not be able to attend all meetings listed on the referral form. Where possible, provide us with 2 weeks-notice for any meetings to allow the advocate adequate time to support the advocacy partner.** | | | | | | | | |
| **The referrer is responsible for providing ASIST with accurate, up to date information and contact details, and updating ASIST with any new information or, amendments to information provided on the referral form after it has been submitted. PLEASE make sure information is correct before submitting this form.** | | | | | | | | |
| **ASIST provides the IMCA service across Stoke and Staffordshire.**  **All referrals should be made by completing the attached form and sending it by e-mail or post.**  **During periods of high demand on the IMCA service, Serious Medical Treatment and 39A DoLS referrals will be given priority over Safeguarding referrals and accommodation reviews.** | | | | | | | | |
| **For further information you can contact Asist, or the Local Authority Adult Protection Co-ordinators at:** | | | | | | | | |
| **Peter Hampton, Adult Protection Co-ordinator, Staffordshire County Council on 01785 895676 peter.hampton@staffordshire.gov.uk** | | | **Jackie Bloxham Adult Protection Co-ordinator, Stoke on Trent City Council on 01782 232396 Jackie.Bloxham@stoke.gov.uk** | | | | | |
| **To discuss a referral please contact Asist on 01782 845584**  **Fill in this form and send to Asist by emailing** [**referrals@asist.co.uk**](mailto:referrals@asist.co.uk)  **Head Office: Asist, Winton House, Stoke Road, Stoke-on-Trent, ST4 2RW.** | | | | | | | | |

Service available Monday to Friday 9am to 5pm (excluding bank holidays)

