Swindon Advocacy Movement
Swindon Advice and Support Centre
Sanford House
Sanford Street
Swindon
SN1 1QH
IMCA on 01793 616562/542575
Fax Number 01793 423124

IMCA REFERRAL FORM

Confidential

Swindon Advocacy Movement's IMCA service provides an Independent mental Capacity Advocate to represent and support people who meet any of the following criteria:

1. The person does not have appropriate family or friends to represent them and lacks capacity to make decision concerning either:

   a. Serious medical treatment
   b. Long term accommodation moves (move than 28 days in a hospital/8 weeks in a care home).

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

3. The IMCA may also be asked to attend Care Reviews.

PLEASE ATTACH CAPACITY ASSESSMENT

	Client Details		
Name:			
Date of Birth:			
Home Address: **Post Code:**		**Telephone Number**	
Home Owner	Living with Family	Social Housing Tenant	Care Home
Private Tenant	Supported Living	Hospital	Warden Controlled
G.P's Name			
G.P's Address:			
G.P's Phone Number			
Children under 18:	Yes: Number:	No:	
Carer:	Yes:	No:	
Personal Budget:	Yes:	No:	
In Receipt of Benefits	Yes	No	

Name of referrer		Telephone	Mobile
Address Post Code:			
Email		Date of referral:	

Name of decision maker (if different)		Telephone	
Address Post Code:			
Email		Mobile	

Primary communication	English	Another spoken language	Gestures/ vocalisations/ facial expressions
	BSL	other (please specify)	No obvious communication
	Pictures/ symbols / signs		
What is the understanding of the person's ability 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 person's capacity made?	Decision maker's judgement	Assessment by another professional	Other (please specify)
Please enter details about the most recent capacity assessment.	Date:	Assessor's name:	Assessor's job title:

PLEASE ATTACH CAPACITY ASSESSMENT TO THIS REFERRAL FORM								
Client group/reason for lacking capacity (please tick)	Learning Disability		Autistic Spectrum Disorder		Mental health		Serious Physical Illness	
	Dementia		Acquired brain injury		Unconscious		Other	
What is the decision to be made about? (Please tick)	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? (Please tick one	Own home		Care/ nursing home		General Hospital		Psychiatric hospital	
	Uncertain		Other					
Current address if different to page 1								
What is the decision makers recommended course of action?								
Are there any family or friends?	Yes		No		Uncertain			
If there are family or friends, why is an IMCA needed?								
Names and contact details of anyone who may be able to indicate the person's wishes (e.g. care manager, GP, nurses, other significant person)								

Please give any facts relevant to the person's wishes or perceived interests	
Any other relevant information	

Risk Assessment:
This section needs to be completed in order for us to provide a service to the client. Please indicate below anything in the client's history or health needs which may give rise potential risks or dangers either to themselves or to others. Please be aware, advocates are lone workers who often visit clients at home.
Any known mental health issues:
Any behaviours we need to know about:
Any known risks in lone working/visiting at home i.e. friends, family, history etc:
Any particular health needs i.e. Epilepsy, Asthma etc:
Any particular communication needs:
Any other details we need to be aware of:

Please return this form by fax, email or post

Swindon Advocacy Movement, Sanford House, Sanford Street, Swindon, SN1 1QH.

Tel: 01793 616562/542575
Fax: 01793 423124 ***Web:*** *swindonadvocacy.org.uk* **email:** imca@swindonadvocacy.org.uk

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"Swindon Advocacy Movement is committed to safeguarding and promoting the welfare of children, young people and adults. Swindon Advocacy Movement expects all staff and volunteers to share that commitment.

In accordance with the Data Protection Act 1998, all information provided on the referral form and in any further dealings with Swindon Advocacy Movement will be treated as confidential and will not be disclosed to any third party without express consent from the client.

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EQUAL OPPORTUNITY MONITORING FORM

Swindon Advocacy Movement is committed to managing diversity and ensuring equality of opportunity for all. We will treat all cases fairly and equally in all aspects of their race, disability, gender, age, religion or belief, sexual orientation, marital status, pregnancy, maternity and sex.

In order to ensure the continued development of our Equal Opportunities and Diversity Policy all Clients are asked to complete the details below. The information will be used solely for monitoring purposes and will be treated as confidential.

Client Details							
I am:	Married	Single	Divorced/ Separated	Widowed	Prefer not to say		
My Gender Is:	Male	Female	Transgender	Prefer not to say			
Sexuality:	Heterosexual	Homosexual	Lesbian	Bisexual	Prefer not to say		
My Religion is:	Christian	Muslim	None	Prefer not to say			
	Sikh	Hindu	Other (please state)				
Employment Status:	Employed	Unemployed	Registered Disabled	Retired			
Age Groups	16-24	25-34	35-44	45-54	55-64	65+	Prefer not to say
I am	Pregnant	Or Maternity	Prefer not to say	Not applicable			
Post Code:							

Ethnicity:			
White British		Asian – British or Indian	
White Irish		Asian – British or Pakistani	
White Other		Asian – British or Bangladeshi	
Please specify;		Any other Asian background	
Mixed – White & Black Caribbean		Black – British or Black Caribbean	
Mixed – White & Black African		Black – British or Black African	
Mixed –White & Asian		Other Black	
Mixed – White Other		Oriental - Chinese	
Any other mixed background		Oriental – Other	
		Not Established	

Disability:							
Do you consider yourself to have any long-standing illness or disability that affects your daily activities or the work that you do? **Please tick**							
Yes		**No**		**Prefer not to say**			
If you have answered yes to the question above, how would you best describe your disability. **Please tick all that apply**							
Hearing		**Speech**		**Physical**		**Mental Health**	
Visual		**Mobility**		**Learning**		**Other**	