



Name		Date of Birth	
Current address		Home Address	
Postcode		Postcode	
Primary Contact Name		Primary Contact Number	

Consent

Does the person consent to their information in this referral being kept by us and shared with the most appropriate advocacy organisation within the Hampshire Advocacy consortium?	YES / NO Details
If the person does not have capacity to consent to share, do you consider it in their best interests for their information in this referral to be kept by us and shared with the most appropriate advocacy organisation within the Hampshire Advocacy consortium?	YES / NO Details of best interests decision
Please explain if you have had difficulties with consent for this referral	

Issue Details	Serious Medical Treatment:		Care Review*:	
	Change in Accommodation*:		Safeguarding*:	
Give brief details of decision and/or issues (continue separately as required):				
Date of Mental Capacity Assessment		Assessed by		

*Please note that some clients may also have a statutory entitlement to advocacy under the Care Act for support with the local authority assessment, care planning, review or Safeguarding processes. Where this is the case, the advocate will request additional referral information and Care Act Advocacy will be offered alongside or instead of the IMCA role as appropriate.

Significant Dates / Information	
Details of any impending meetings or deadlines:	
How does the client communicate?	

Specific Needs (access issues, etc):	
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Others involved
Is this client befriended? Yes / No (See MCA Code 10.74 to 10.80 – Who is ‘appropriate to consult’)
Details of professionals / others involved, give contact details (continue separately as required):

Any other Advocates that are working with the client
Name and advocacy organisation, give contact details

Decision Maker Name:			
Job Title:		Phone No:	
Address & Postcode:			
Email:			
Referrer Name (If different):			
Job Title:		Phone No:	
Address & Postcode:			
Email:			

Nature of Impairment					
Unconsciousness		Serious Physical Illness		Learning Disability	
Autism Spectrum Condition		Acquired Brain Injury		Cognitive Impairment	
Mental Health Problems		Dementia		Combination	
Other (please specify):					

Ethnic Background							
White:		Black / British:		Asian / British:		Mixed:	
White British		Black Caribbean		Indian		White & Black Caribbean	
White Irish		Black African		Pakistani		White & Black African	
Other White*		Other Black*		Bangladeshi		White & Asian	
				Other Asian*		Other Mixed White*	
Other ethnicities:	Chinese			Any Other Ethnicity*		Not Known / Stated	
*Specify Other:							

Decision Maker’s Confirmation

I am the Decision Maker for decisions relating to:

Client Name: _____

On behalf of:

NHS Body – Specify: _____

Local Authority – Specify: _____

I confirm that I deem the above client lacks capacity for the above decision

MCA Code of Practice: <http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf>

I am instructing the IMCA service to do this work. I am authorised by the NHS organisation or local authority responsible for making this decision.

Print Name: _____

Signed: _____

Date: _____

Please return completed form to us:

By email to advocates@easthantsmind.org

By fax to 023 92481886

By post to Havant & East Hants Mind, Leigh Park Community Centre, Dunsbury Way,
Havant PO9 5BG

Telephone enquiries 023 92484422

Hampshire Advocacy Service delivers advocacy provision as a partnership of five organisations. We have a commitment to work together to provide a seamless service for individuals. As part of this, we may need to share individual information across the partnership. We are committed to ensuring that this is done only where necessary, with your permission where possible, with management agreement and according to our sharing protocol guidelines.

Registered Company number: 11056120 Website: www.hampshireadvocacy.org.uk