

**Havering Statutory Independent Advocacy Service**

**IMCA/RPPR DoLS Referral Form**

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| **Date of referral:** |  |
| **Client name:** |  |
| **Date of Birth:** |  |
| **Gender:** | Choose an item. |
| **Where is the client currently?** **(at date of referral):** |  |
| **Telephone Number:** |  |
| **Mobile phone number:** |  |
| **Permanent address (if relevant):** |  |
| **What is the best interest decision?** | Choose an item. |
| **If other, please state:** |  |
| **Authorisation starts** **(if relevant):** |  |
| **Authorisation ends** **(if relevant):** |
| **Details of Mental Capacity Assessment** |
| **Name of the professional who has deemed the referred person as lacking the mental capacity to make a decision about the referral issue:** |  |
| **What is their position?** |  |
| **Has a stage 2 functional assessment of capacity been carried out?** | **Yes**[x]  | **No**[ ]  |
| **Does the referred person have a family member or friend who is considered appropriate to be involved? in the best interest decision?** | **Yes**[ ]  | **No**[x]  |
| **If yes, please state family details:** |  |
| **If NO, what is the reason the family/friends are not involved?** |  |
| **Support, Risk and Communication** |
| **Please detail any support needs the advocate will need to provide:** |  |
| **Are there any current risks regarding the client that we need to be aware of?** | **Yes**[ ]  | **No**[x]  |
| **If YES, please describe details of risk:** |  |
| **Has a risk assessment been carried out?** | **Yes**[ ]  | **No**[ ]  | **N/A**[x]  |
| **Does the client have any communication needs?** | **Yes**[ ]  | **No**[x]  |
| **If YES, please provide details:** |  |

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| **Professional Contact Details** |
| **Name of person making the best interest decision:** |  |
| **What is their role?** |  |
| **Organisation and address details:** |  |
| **Telephone Number:** |  |
| **Email:** |  |
| **Name of social worker and contact details:** |  |
| **Please list any other relevant professionals who may be involved in the process:** |  |
| **Is the client aware of the referral being made?** | **Yes**[x]  | **No**[ ]  | **N/A**[ ]  |
| **Signature (referrer):** |  |
| **Please return the completed form to:** | advocacy@haveringmind.org.uk  |

Havering Statutory Independent Advocacy Service will confirm receipt of your referral within two working days. If you have not received this confirmation, please contact the service on advocacy@haveringmind.org.uk or call 01708 457040.

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| **Equal Opportunities Monitoring Details – please complete** |
| **Client Religion:** | Choose an item. |
| **Client Sexuality:** | Choose an item. |
| **Client Ethnicity:** | Choose an item. |
| **Do you have a disability?** | Choose an item. |
| **If yes, please state:** |  |