

Chart

Description automatically generated with low confidence**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** | | **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** | |
| **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** | | |
| **If YES, please describe details of risk:** |  | | | | |
| **Has a risk assessment been carried out?** | **Yes** | | **No** | | **N/A** |
| **Does the client have any communication needs?** | **Yes** | | **No** | | |
| **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** | **No** | **N/A** |
| **Signature (referrer):** | | |  |
| **Please return the completed form to:** | | | [advocacy@haveringmind.org.uk](mailto: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](mailto: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:** |  |