

**Havering Statutory Independent Advocacy Service**

**IMHA/Care Act Referral Form**

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| **Date of referral:** |  |
| **Client name:** |  |
| **Date of Birth:** |  |
| **Gender:** | Choose an item. |
| **Permanent address:** |  |
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| **Telephone Number:** |  |
| **Mobile Number:** |  |
| **Email address:** |  |
| **Where did you hear about the service?** | Choose an item. |

**Where Is the Client Currently?**

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| **Ward:** |  |
| **Hospital/Care Home Address:** |  |
| **Post Code:** |  |
| **Telephone Number:** |  |

**Monitoring Details:**

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| --- | --- |
| **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:** |  |

**How Does the Patient Qualify for Statutory Advocacy?**

**(Please select and provide relevant date)**

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| **The patient is detained under section 2 of the Mental Health Act 1983:** | **Please select:** | **Section start date:**  |
| **The patient is detained under section 3 of the Mental Health Act 1983:** |[ ]  **Section start date:**  | Click or tap to enter a date. |
| **The patient is detained under part 3 of the Mental Health Act 1983 (‘forensic’ / ‘forensic restricted’ patients) (specify section with issue details below)** |[ ]  **Section start date:**  | Click or tap to enter a date. |
| **Is the patient a conditionally discharged restricted patient?** **If yes, select section below:** | Choose an item. |
| **The patient is subject to a Community Treatment Order (CTO) under the Mental Health Act 1983:** |[ ]  **Section start date:**  | Click or tap to enter a date. |
| **The patient is subject to a Guardianship Order under the Mental Health Act 1983:** |[ ]  **Section start date:**  | Click or tap to enter a date. |
| **The patient requires Advocacy support under the Care Act 2014 (assessment, care planning, care plan review or safeguarding?)** |[ ]   |  |
| **If Care Act, please state category:**  | Choose an item. |  |  |

**For What Issue/s Is an Advocate Being Requested?**

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| *Continue on separate sheet if necessary* |

**Are There Deadlines / Important Dates Relevant to the Issue/s?**

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## **Communication Needs**

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| **Does the client have any communication needs? (Please select)** | **Yes**[ ]  | **No**[ ]  |
| If so, please describe: |

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| --- | --- | --- |
| **Are there any current known risks regarding the patient that we need to be aware of? (Please select)** | **Yes**[ ]  | **No**[ ]  |
| If so, please describe: |
| **Has a risk assessment been carried out?** | **Yes**[ ]  | **No**[ ]  |

**Referrer Details**

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| **Name of Referrer** |  |
| **Relationship to Client (Please select)** | Choose an item. |
| **If professional, please provide title:** |  |
| **Referrer Address details, if different from client detail:** |  |
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| **Postcode:** |  |
| **Telephone Number:** |  |
| **Email address:** |  |
| **How did you hear about the service?** | Choose an item. |

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| **For Professionals** |  | **Please select** |  |  |
| **Has the patient provided consent for this referral to be made?**  | **Yes**[ ]  | **No**[ ]  |
| **Is there any query regarding the patient’s capacity?**  | **Yes**[ ]  | **No**[ ]  |
| If yes, please state: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name or Signature of referrer** |  | **Date** | Click or tap to enter a date. |

Please email your referrals form to advocacy@haveringmind.org.uk

Telephone: 01708 457040