IMCA Referral

Independent Mental Capacity Advocacy

What is the Independent Mental Capacity Advocate (IMCA) Service and how does it work?

The purpose of the IMCA service is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about these decisions, or about care reviews or Adult Protection proceedings.

The IMCA service safeguards the rights of people aged 16 years and over who:

- **Lack capacity to make a specified decision at the time it needs to be made**

The Mental Capacity Act 2005 (MCA) says everyone has the right to make their own decisions and must be given all practicable help to do so before they are deemed as lacking capacity. In order to process this referral, we require confirmation that an appropriate mental capacity assessment has been undertaken. The person's capacity must be assessed in relation to the decision to be made. Generic assessments of capacity are not sufficient.

and

- **Have nobody else who is willing and able to represent them or be consulted in the process of working out their best interests, other than paid staff**

NHS and Local Authority Decision Makers need to determine if there are family or friends who are willing and able to be consulted about the proposed decision. If not, an IMCA will work with and support people who lack capacity, and represent their views to those who are considering their best interests in accordance with the MCA.
If a decision needs to be taken about a Care Review or Safeguarding case, there is now a statutory duty to refer under the Care Act 2014, and an ICAA referral should be made for an Independent Care Act Advocate.

0 Office Use Only

Case reference

Date referral received

Advocacy service referred to

Advocate/Team

1 Referrer Details

Date of referral

Organisation

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1 Referrer Details cont.

First Name

Last Name

Address

Postcode

Telephone Number

Email Address

Mobile Number

Job Title/Relationship to Client

Doctor ☐	Psychiatrist ☐	Ward Manager ☐
Care Manager ☐	Care Home Manager ☐	Team Manager (Health) ☐
Team Manager (Social) ☐	Social Worker (Hospital) ☐	Social Worker (Community) ☐
Nurse (Health Professional) ☐	Administrator ☐	

Other (please specify)

2 Client Details

Title

Date of Birth

First Name

Last Name

Permanent Address

Postcode

Telephone Number

Email Address

Mobile Number

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2 Client Details cont.

Current Address (if different from permanent)

Postcode

Telephone Number

Location Setting

Own home	☐	Own home (with support)	☐	Supported Living	☐
Hospital	☐	Care/Nursing Home	☐	Dementia Ward	☐
Acute Psychiatric Ward	☐	Forensic Secure Unit	☐	Prison	☐
Homeless	☐	No fixed abode	☐		

Other/Ward Name (if in hospital)

Preferred method of contact

Any	☐	Phone	☐	Mobile	☐
SMS (Text)	☐	Email	☐	Post	☐
No Direct Contact	☐				

Is English Spoken?

Yes ☐ No ☐ Not known ☐

Primary Communication Method

Spoken English	☐	Other spoken language (specify below)	☐
Words/Pictures/Makaton	☐	Gestures/Expressions/Vocalisations	☐
British Sign Language (BSL)	☐	No Obvious Means	☐
Not known	☐		

Other (please specify other spoken languages here)

Does the client identify as having a disability?

Yes ☐ No ☐ Not known ☐ Prefers not to say ☐

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2 Client Details cont.

Does the client have a diagnosed or recognised disability? (select all that apply)

- Mental Health Condition ☐
- Acquired Brain Injury ☐
- Serious Physical Illness ☐
- Physical Disability ☐
- Learning Disability ☐
- Cognitive Impairment ☐
- Sensory (Visual) ☐
- Sensory (Auditory) ☐
- Dementia/Alzheimer's ☐
- Asperger's/Autistic Spectrum Condition ☐
- Unconsciousness ☐

Other (please specify)

Is there one disability which is most relevant to the case? (If there is not, leave blank)

- Mental Health Condition ☐
- Acquired Brain Injury ☐
- Serious Physical Illness ☐
- Physical Disability ☐
- Learning Disability ☐
- Cognitive Impairment ☐
- Sensory (Visual) ☐
- Sensory (Auditory) ☐
- Dementia/Alzheimer's ☐
- Asperger's/Autistic Spectrum Condition ☐
- Unconsciousness ☐

Military Connection

- Serving ☐
- Veteran ☐
- Carer relationship ☐
- No ☐
- Not known ☐
- Prefers not to say ☐

Gender

- Male ☐
- Female ☐
- Trans (Male to Female) ☐
- Trans (Female to Male) ☐
- Not known ☐
- Prefers not to say ☐

Other (please specify)

Marital/Civil Partnership Status

- Single ☐
- Co-habiting ☐
- Married ☐
- Civil Partnership ☐
- Divorced/Dissolved ☐
- Separated ☐
- Widowed ☐
- Surviving (Civil Partnership) ☐
- Not known ☐
- Prefers not to say ☐

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2 Client Details cont.

Sexual Orientation

Lesbian ☐ Gay Man ☐ Heterosexual ☐
Bisexual ☐ Questioning ☐ Not known ☐
Prefers not to say ☐
Other (please specify)

Belief

Buddhist ☐ Christian ☐ Hindu ☐
Jewish ☐ Muslim ☐ Sikh ☐
No Religion ☐ Not known ☐ Prefers not to say ☐
Other (please specify)

Ethnicity

Asian/Asian British

Indian ☐ Pakistani ☐
Chinese ☐ Bangladeshi ☐
Other (please specify)

Black/Black British

African ☐
Caribbean ☐
Other (please specify)

White

British ☐
Irish ☐
Gypsy/Traveller ☐
Other (please specify)

Mixed

White & Black Caribbean ☐
White & Black African ☐
White & Asian ☐
Other (please specify)

Other

Arab ☐
Other (please specify)

Not known ☐
Prefers not to say ☐

Does the client identify as Cornish?

Yes ☐ No ☐ Not known ☐

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3 Case Details

Is this a first referral?

Yes ☐ No ☐ Not known ☐

Has the client been assessed as lacking capacity to make a particular decision?

Yes ☐ No ☐

This referral cannot be processed without a Mental Capacity Assessment having been completed. (The details below are not essential for referral, but must be supplied as soon as possible)

Assessment date

Who carried out the assessment?

Where are the notes held?

What steps were taken? (if known)

Is the client detained under any section of the Mental Health Act?

Yes ☐ No ☐ Not known ☐

Are there any friends/family/others who are considered willing and able to be consulted about the decision being made? (This does not apply to Adult Protection Proceedings)

Yes ☐ No ☐

If yes, give details of concerns about their involvement

Select the IMCA instruction which is the subject of this case

Change of Accommodation ☐ Adult Protection Proceedings ☐

Serious Medical Treatment ☐ Care/Accommodation Review ☐

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3 Case Details cont.

Enter details of the decision being made

What date does the decision need to be made by?

Enter details of any relevant meetings already arranged

Enter details of any Advance Directive or other record of the clients wishes

If there are any risks we should be aware of give details (otherwise state 'no known risks')

Who can make arrangements for the initial client meeting? (If Other, enter the details below, otherwise continue to section 4)

Referrer ☐ Decision Maker ☐

Other ☐

Organisation

First Name

Last Name

Address

Postcode

Telephone Number

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3 Case Details cont.

Email Address

Mobile Number

Job Title/Relationship to Client

Doctor ☐ Ward Manager ☐ Nurse (Health Professional) ☐

Care Manager ☐ Care Home Manager ☐ Administrator ☐

Other (please specify)

4 Decision Maker Details

If the **Decision Maker** is different to the referrer, fill out this section, otherwise continue to Section 5 Declaration (the Decision Maker is the person ultimately responsible for the decision being made)

Are they aware of this referral?

Yes ☐ No ☐

Organisation

First Name

Last Name

Address

Postcode

Telephone Number

Email Address

Mobile Number

Job Title/Relationship to Client

Doctor ☐ Ward Manager ☐ Nurse (Health Professional) ☐

Care Manager ☐ Care Home Manager ☐

Other (please specify)

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5 Declaration

In making this referral, I declare that:

- I would like to instruct an IMCA and am authorised to do so.
- I am providing this information and making this referral in relation to the Mental Capacity Act 2005.
- I confirm that an appropriate Mental Capacity Assessment has been undertaken for the client.
- In accordance with current Data Protection legislation, I agree to The Advocacy People and their delivery partners holding personal information (including information on this form).
- I understand the provision of an advocacy service is subject to the client meeting eligibility criteria.

Please email the completed form to: **info@theadvocacypeople.org.uk**
or post to: **P.O. Box 375, Hastings, TN34 9HU**

If you have not received confirmation of this referral within **2 working days**, or you would like to discuss any aspects of a referral, please call **0330 440 9000**.

By requesting advocacy support, you give consent to The Advocacy People sharing information, as required for the purposes of providing the service.
For more information on our Privacy Notice, please ask your advocate or go to www.theadvocacypeople.org.uk/privacy

Confidentiality
Communications between you and The Advocacy People are confidential. We will not divulge any information without your permission unless disclosure is required or permitted by law, e.g. where you tell us something which leads us to believe you or someone else may be at risk of serious harm or abuse or committing a serious criminal offence, where there is a court order for disclosure, or where we would be breaking the law by failing to disclose.

All records are held by The Advocacy People in accordance with current Data Protection legislation.

The Advocacy People