Hartlepool Advocacy Hub
IMCA Referral Form
April 2018

GUIDANCE:

Not providing the necessary information could affect response times. Please complete the form in full, including signatures and dates. *NB – we are unable to accept referrals directly by Email, or Fax, unless through 'Anycomms'* – advocacyhub@incontrol-able.co.uk

Discuss this referral to the Advocacy Hub with the patient/individual for the Advocacy Hub to identify an IMCA from the Provider Framework.

Give the patient/individual the opportunity to decide whether to request advocacy support themselves.

Consider referring to the Advocacy Hub if you think the patient/individual may benefit from IMCA support, but is unable, or unlikely to request support themselves.

This form is subject to review to maintain service provision and monitoring.

PLEASE RETURN THE COMPLETED FORM TO:

Hartlepool Advocacy Hub, c/o Incontrol-able CIC, Centre for Independent Living, Burbank Street, Hartlepool TS24 7LT.

CLIENT DETAILS:

Name:					
Gender:	M	F	O	DOB:	
Permanent Address:					
Postcode:				Telephone:	
Current Location:					
Postcode:				Telephone:	

ETHNIC BACKGROUND *(Please tick box that applies)*

White British		Black/Black British (African)	
White Irish		Black/Black British (Caribbean)	
White (Other Background)		Black/Black British (Other Background)	
Mixed: White/Black African		Asian/Asian British (Bangladeshi)	
Mixed: White/Black Caribbean		Asian/Asian British (Indian)	
Mixed: White/Asian		Asian/Asian British (Pakistani)	
Mixed: (Other Background)		Asian/Asian British (Other Background)	
Chinese		Other Ethnic Group	

Any identified religious, cultural or spiritual needs?

Are there any relevant risks that the IMCA should be aware of? (eg: behaviour, security issues, exposure to infection). If yes please give brief details.			
REFERRAL DETAILS:			
Referrer:			
Role:			
Address:			
Postcode:		Telephone:	
Email:		Fax:	

REASON FOR REFERRAL		
Serious Medical Treatment	YES	NO
Change of Accommodation	YES	NO
Adult Protection	YES	NO
Care Review	YES	NO
Deprivation of Liberty - Section 39A	YES	NO
Deprivation of Liberty - Section 39C	YES	NO
Deprivation of Liberty - Section 39D	YES	NO

BRIEF DETAILS OF THE SITUATION THAT REQUIRES IMCA INVOLVEMENT:
(please indicate) Has the patient/individual received IMCA support before? **YES/NO/DON'T KNOW** If yes, name of Advocate/Provider:
ARE THERE ANY DEADLINES OR IMPORTANT MEETING DATES?

	YES	NO	NOT KNOWN

CONTACT DETAILS:			
Care Coordinator:			
Address:			
Postcode:		Telephone:	
Email:		Fax:	

GP:			
Address:			
Postcode:		Telephone:	
Email:		Fax:	

DECLARATION:

Because of the General Data Protection Regulations 2018, a signature is needed to say that you agree to the Advocacy Hub securely holding personal information (including the information on this form), on a computer and in a filing system. It is the policy of the Advocacy Hub that all personal data will be held in accordance with the principles and requirements of General Data Protection Regulations 2018 and other relevant legislation, and that procedures will be put in place to ensure the fair processing of data relating to individuals. The Advocacy Hub is a confidential service; you can request further information on confidentiality from ourselves, or the appropriate IMCA service.

I agree that the Advocacy Hub can securely hold, and put on computer and in a filing system, the information on this form.

MUST BE SIGNED AND DATED.

SIGNATURE	
PRINT NAME	
DATE	