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| **Hartlepool Adult Social Care Advocacy IMCA Referral Form****October 2023** |
| **GUIDANCE:** |
| **Not providing the necessary information could affect response times. Please complete the form in full, including signatures and dates.** ***NB –*** *we accept referrals directly by Email at:-* *adultscommissioning@hartlepool.gov.uk*Discuss this referral to Adult Social Care Advocacy with the patient/individual for HBC Advocacy 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 Advocacy 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 VIA EMAIL**  |
| **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? |
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| 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. |
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| **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 HBC securely holding personal information (including the information on this form), on a computer and in a filing system. It is the policy of HBC 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. You can request further information on confidentiality from ourselves, or the appropriate IMCA service.*I agree that the HBC 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 |  |