

**HAVERING INTEGRATED ADVOCACY SERVICE**



**REFERRAL FORM**

**IMHA/Care Act/NHS Complaints**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of referral:** |  | | | |
| **Client Name:** |  | | | |
| **Date of Birth:** |  | |  | |
| **Gender:** | Male | Female | Transgender | Prefer not to say |
| **Permanent address:** |  | | | |
|  | | | |
|  | | | |
|  | | | |
| **Post Code:** |  | | | |
| **Telephone Number:** |  | | | |
| **Mobile Number:** |  | | | |
| **Email Address:** |  | | | |

**Where Is the Client Currently?**

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

**Monitoring Details:**

|  |  |  |
| --- | --- | --- |
| **Client Religion:** |  | Prefer not to say |
| **Client Sexuality:** |  | Prefer not to say |
| **Client Ethnicity:** |  | |
| **Client Disability:** | Yes  If yes, please state: | No |
| **As a woman, are you pregnant, on maternity leave or returning from maternity leave?** | Yes/No | Prefer not to say |

**How Does the Patient Qualify for Statutory Advocacy? (Please tick🗸 and provide relevant date)**

|  |  |  |  |
| --- | --- | --- | --- |
| **The patient is detained under section 2 of the Mental Health Act 1983:** |  | **Section start date:** |  |
| **The patient is detained under section 3 of the Mental Health Act 1983:** |  | **Section start 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:** |  |
| **Is the patient a conditionally discharged restricted patient? State section below.** |  |  |  |
| **The patient is subject to a Community Treatment Order (CTO) under the Mental Health Act 1983:** |  | **Section start date:** |  |
| **The patient is subject to a Guardianship Order under the Mental Health Act 1983:** |  | **Section start date:** |  |
| **The patient requires Advocacy support under the Care Act 2014 (assessment, care planning, care plan review or safeguarding?)** |  |  |  |
| **The client wishes to make a formal NHS Complaint** |  |  |  |

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

|  |
| --- |
| *Continue on separate sheet if necessary* |

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

|  |
| --- |
|  |

## **Communication Needs**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Does the client have any communication needs? (Please tick🗸)** | **Yes** |  | **No** |  |
| If so please describe: | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Are there any current known risks regarding the patient that we need to be aware of? (Please tick√)** | **Yes** |  | **No** |  |
| If so please describe: |  |  |  |  |

**Referrer Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Referrer** | Self / client | | | |
| **Relationship to Client (Please tick🗸):** | **Professional** |  | **Family / Other** |  |
| **If professional, please provide title:** |  | | | |
| **Contact Address:** |  | | | |
|  | | | |
|  | | | |
|  | | | |
| **Postcode:** |  | | | |
| **Telephone Number:** |  | | | |
| **Email address:** |  | | | |

**For Professionals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | **Please tick (√)** | |  |  |
| **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** |  |

Please email your referrals form to [havering.advocacy@mithn.org.uk](mailto:havering.advocacy@mithn.org.uk)