

**Independent Mental Capacity Advocacy Referral Form**

Please complete this form in full and return to [referrals@solihulladvocacy.org.uk](mailto:referrals@solihulladvocacy.org.uk) or return by post to: Solihull Action through Advocacy, 11-13 Land Lane, Marston Green, Solihull, B37 7DE

If you need support to complete this referral form, please contact us on 0121 706 4696.

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| Date of Referral: Click or tap to enter a date. |

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| Section A: About the referrer | |
| Name of person making referral:  Click or tap here to enter text. | Organisation referrer works for (if applicable):  Click or tap here to enter text. |
| Job Title (if applicable):  Click or tap here to enter text. | Telephone Number: Click or tap here to enter text.  Email Address: Click or tap here to enter text. |

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| Section B: About the person requiring support | |
| Name:  Click or tap here to enter text. | Date of Birth:  Click or tap to enter a date. |
| Home Address:  Click or tap here to enter text. | Telephone Number: Click or tap here to enter text. |
| Mobile: Click or tap here to enter text. |
| Email Address: Click or tap here to enter text. |
| Care First ID (if known): Click or tap here to enter text. |
| Postcode: Click or tap here to enter text. |

If the person requiring support has an alternative contact person (e.g. parent/carer) please detail below:

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| Name of alternative contact (if applicable):  Click or tap here to enter text. | Contact Telephone:  Click or tap here to enter text. |

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| Full address of current location (if not at home):  If in hospital, please include hospital name and ward name/number  Click or tap here to enter text. | Telephone Number at current location:  Click or tap here to enter text. |

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| How does the person communicate? | | | |
| Speech | Words and Pictures | Signing | No Speech |
| Other: Click or tap here to enter text. | | | |

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| What is the person’s first/main language? Click or tap here to enter text. |

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| Section C: Independent Mental Capacity Advocacy referrals only | |
| Reason for referral: (please tick) | |
| Serious Medical Treatment | Move to accommodation |
| Safeguarding Vulnerable Adults | Care Review |
| Please describe the decision being made and the proposed options:  Click or tap here to enter text. | |
| Date by which the decision needs to be made:  Click or tap to enter a date. | Any other deadlines/meetings (including dates):  Click or tap here to enter text. |
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| Has a capacity assessment been completed? | Choose an item. |
| Name of Assessor: Click or tap here to enter text. | Designation (e.g. Social Worker):  Click or tap here to enter text. |
| Date of Assessment: Click or tap to enter a date. |

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| Does the referred person have any family or friends? | | Choose an item. |
| If “Yes but not appropriate willing or able to offer support” please explain | Click or tap here to enter text. | |

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| Name of person making the best interest decision: | Click or tap here to enter text. |
| Position: Click or tap here to enter text. | Organisation: Click or tap here to enter text. |
| Address:  Click or tap here to enter text. | Telephone: Click or tap here to enter text. |
| Mobile: Click or tap here to enter text. |
| Email: Click or tap here to enter text. |

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| Section D: Risk and Safeguarding | |
| Risks:  Please detail any information relevant to ensuring the safety of the person or of the advocate (or both)  Click or tap here to enter text. | Safeguarding:  Please detail any existing safeguarding concerns that the advocate should be aware of  Click or tap here to enter text. |

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| Section E: Consent |
| Where possible and appropriate, have this referral been discussed with the person? Choose an item. |
| If “No”, please explain why:  Click or tap here to enter text. |
| Has the person consented to this referral being made? Choose an item. |

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| Section F: Equality Monitoring  This information is collected to ensure that we provide an accessible and responsive service to all. It is not mandatory to complete all of these questions but it will support us to develop and improve our services if you can answer as many of them as possible. Thank you. | | | |
| Gender: Choose an item. | | Religion: Choose an item. | |
| Ethnicity: Choose an item. | | Sexual Orientation: Choose an item. | |
| Do you/does the person consider yourself/them self to have: (please tick all that apply) | | | |
| A learning disability | A physical disability | | Mental ill health |
| A sensory impairment | Dementia | | Autism |
| An acquired brain injury | A chronic health condition | | Prefer not to say |
| Other (please specify): Click or tap here to enter text. | | | |

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| **For Internal Use Only** |  |
| Date referral received | Click or tap to enter a date. |
| Channel of receipt | Choose an item. If other, please specify: Click or tap here to enter text. |
| Referral successful? | Choose an item. |
| If not successful, why? | Click or tap here to enter text. |
| Date advocate allocated | Click or tap to enter a date. |
| Name of advocate | Click or tap here to enter text. |
| Date client first contacted | Click or tap to enter a date. |