

**IMHA Referral Form**

[referral@advocacyhub.org.uk](mailto:referral@advocacyhub.org.uk)

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| --- | --- | --- | --- |
| **Name:** |  | | |
| **Current address:**  (hospital, unit, residential home) |  | | |
| **Home address:**  (incl postcode) |  | | |
| **Telephone:** |  | **Mobile:** |  |

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| --- | --- | --- | --- | --- | --- |
| **Date of birth:** |  | **Gender:** |  | **Ethnicity:** |  |

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| --- | --- |
| **Does the person have capacity to consent to the referral?** | **Yes No Unsure** |
| **If YES has consent been obtained for this referral?** | **Yes No** |

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| **Plea Please detail any risk or incidents the advocacy service should be aware of:** |

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| **Please confirm that the person is a qualifying patient for IMHA services:**  What section detained under? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of section? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sections a patient is liable to be detained under:  s.2 (assessment), s.3 (treatment), s.35 (remand for reports), s.36 (remand to hospital), section 37 & 38 (court hospital orders), section 47 (prison transfer), section 48 (prison transfer on remand/civil prisoner).  **N.B. Patients on Holding power sections (Sections 5(2), s.5(4), 135, s. 136) are not eligible for IMHA Services.**  **Patients on an s.4 (urgent assessment) are not eligible until and unless it is converted to a s.2.**  **The patient is on a Community Treatment Order**   * Section 17a (community treatment orders)   **The patient is subject to Guardianship**   * s.7 and s.37 (guardianship civil and via courts**)**   **The patient is a conditionally discharged restricted patient**  **The patient is an informal patient but (s.57) medical treatment is being proposed**  (see CoP para 20.6)    **The patient is under 18 and is being considered for ECT or any other s.58A treatment** |

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| **Please give brief details on any specific needs ie communication, sensory, physical:** |

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| **Please provide any forthcoming meeting dates and any other relevant information:** |

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**Referrer details**

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| --- | --- | --- | --- |
| **Name:** |  | | |
| **Role/relationship to patient** |  | | |
| **Organisation** (if applicable) |  | | |
| **Team** |  | | |
| **Contact number:** |  | **Mobile:** |  |
| **Email address:** |  | | |

**Referrer’s statement**

*I believe the patient is eligible for support from an IMHA and I am authorised by my organisation to make this referral.*

Signed: Date:

*By making this referral you give consent to Warrington Speak Up holding and sharing information as required for the purpose of providing the IMHA service.*

Please email this form (password protected) to [referral@advocacyhub.org.uk](mailto:referral@advocacyhub.org.uk)

You will be contacted within **three to five working days** of receipt.

For more information contact **Speak Up Advocacy Hub** on **01925 246 888.**