



IMCA SERVICES REFERRAL FORM

Bristol Mind IMCA service provides an Independent Mental Capacity Advocate to represent and support people in the following circumstances;

1. The person referred lacks capacity to make a decision concerning:

- **serious medical treatment OR**
- **long term care and health moves (more than 28 days in hospital / 8 weeks in a care home) AND**
- **they have no appropriate family or friends to represent them**

2. Referrals to the IMCA service may also be made when:

- **the person referred is subject to a care review and has no appropriate family or friends to represent them**
- **the person referred is subject to an adult protection case, whether or not appropriate family, friends or others are involved**

Referral Information Please circle (or highlight if using email) where there are options

Name of client / name usually known by		Date of birth	
Address		Gender	
		Contact via?	
Postcode		Telephone	

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

Please return this form to:

Email imca@bristolmind.org.uk

Tel 0117 980 0371

Fax 0117 927 6587

Primary communication	English	Another spoken language	Gestures / vocalisations / facial expressions		
	Pictures / symbols / Makaton	BSL	Other	No obvious communication	
Has the person been referred for an assessment by a Speech and Language Therapist?			Yes	No	

What is the decision to be made about?	Accommodation	Serious medical treatment	Care Review	Adult Protection	
When does the decision need to be made by?					
Funding authority eg Bristol					
Details of any important deadlines or important meeting dates					
Where is the person currently staying?	Own home	Care / nursing home	General Hospital	Psychiatric hospital	Other
If not at address on page 1, please give full details					
What is the decision-maker's recommended course of action?					

What is your understanding of the person's capacity to make this decision?	Lacks capacity at this time (but may regain capacity)	Lacks capacity for the foreseeable future		
On what basis was the decision about the person's capacity made?	Decision-maker's judgement	Assessment by other professional	Other	

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Reason the person lacks capacity	Learning disability	Autistic spectrum disorder	Mental Health issue	Serious physical illness
	Dementia	Acquired brain injury	Unconscious	Other

Does the person have any family or friends?	Yes	No
If the person does have family or friends, why is an IMCA needed?		
Names and contact details of anyone who may be able to indicate the wishes of the person who lacks capacity e.g. Care Manager, GP, Manager of home, care staff, nurses or any other significant person		
Any other relevant information Please include any information required to keep the person and / or the IMCA safe, any known advance decisions or statements etc		

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Name of referrer			
Address		Telephone	
		Mobile	
		Email	
Is the referrer the decision maker?		Yes	No
Name of decision maker if not the referrer			
Address		Telephone	
		Mobile	
		Email	

Consent for referral

The Data Protection Act 1998 requires us to ask for signed authorisation to say that people agree to the Bristol Mind IMCA service holding personal information about them (including the information on this form).

Since the person being referred is deemed to lack capacity, signed authorisation must be provided by the referrer, acknowledging that the person referred lacks capacity to make this decision and that this referral is being made and information provided in the person's best interests.

Consent from the referrer			
I am instructing the Bristol Mind IMCA service to do this work. They may keep and put on computer the information on this form, and any other information required to do the work. I am providing this information and asking for this service in the best interests of the person concerned.			
Has the person been informed of this referral?		Yes	No
Signed		Date	

FOR OFFICE USE ONLY			
Date received		Name of IMCA	

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