Portsmouth Advocacy

mind for better mental health Solent

Independent Mental Capacity Advocacy
IMCA Referral Form

PLEASE COMPLETE THE FORM IN BLOCK CAPITAL LETTERS

SECTIONS 1 -3 MUST BE COMPLETED IN FULL

1. Client Details:

Name:	Date of Birth:
Gender:	Email:
Current Location:	Home address:
Telephone:	Mobile:

2. Ethnic Background:

White:		Black / British:		Asian / British:		Mixed:	
White British		Black Caribbean		Indian		White & Black Caribbean	
White Irish		Black African		Pakistani		White & Black African	
Other White*		Other Black*		Bangladeshi		White & Asian	
				Other Asian*		Other Mixed White*	
Other ethnicities:		Chinese		Any Other Ethnicity*		Not Known / Stated	
*Specify Other:							

3. IMCA Client:

Issue Details	Serious Medical Treatment:		Care Review:	
	Change in Accommodation:		Safeguarding/Adult Protection*:	
Give brief details (continue separately as required):			*Adult protection referrals **must** be open to safeguarding	
Date of Mental Capacity Assessment		**Assessed by**		

Registered Charity No. 1124359 Company number: 6050515
Website: www.solentmind.org.uk

4. Additional Information:

Significant Dates / Information:	
Details of any impending meetings or deadlines:	
How does the client communicate?	
Specific Needs (access issues etc):	

Others involved:	
Is this client befriended? Yes / No	(See MCA Code 10.74 to 10.80 – Who is 'appropriate to consult')
Details of professionals / others involved - give contact details (continue separately as required):	

Decision Makers Name: *person taking responsibility for BI decision*			
Job Title:		Phone No:	
Address & Postcode:			
Email:			
Referrer Name (if different):			
Job Title:		Phone No:	
Address & Postcode:			
Email:			

IMCA MONITORING INFORMATION

Nature of Impairment:

Unconsciousness		Serious Physical Illness		Learning Disability	
Autism Spectral Condition		Acquired Brain Injury		Cognitive Impairment	
Mental Health Problems		Dementia		Combination	
Other (please specify):					

Decision Maker's Confirmation

I am the Decision Maker for decisions relating to:

Client Name: .....

On behalf of: ☐ NHS Body (please specify): .....

☐ Local Authority (please specify): .....

I confirm that I deem the above client lacks capacity for the above decision
MCA Code of Practice:
http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf

I am instructing the IMCA service to do this work. I am authorised by the NHS organisation or local authority responsible for making this decision.

Print Name: .....

Signed: ..... Date: .....

Please return completed form to:
portsmouthadvocacy@solentmind.org.uk
Telephone enquiries: 023 8020 8955

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