Choices Advocacy

mind for better mental health Solent

Portsmouth Advocacy

Independent Mental Capacity Advocacy Referral Form

Name		Date of Birth	
Current address		Home Address	
Postcode		Postcode	
Primary Contact Name		Primary Contact Number	
Is it ok to leave a message? Yes / No			

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

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 Maker Name:			
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):					

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:							

Decision Maker's Confirmation

I am the Decision Maker for decisions relating to:

Client Name: .....

On behalf of: ☐ NHS Body – Specify: .....

☐ Local Authority – 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:** .....

Confidential Fax for completed referrals: 023 8020 8954 - Thank you.
Or email: portsmouthimca@solentmind.org.uk
Please phone 023 9283 7777 to discuss referrals.

Portsmouth Advocacy Service delivers advocacy provision as a partnership of five organisations. We have a commitment to work together to provide a seamless service for individuals. As part of this, we may need to share individual information across the partnership. We are committed to ensuring that this is done only where necessary, with your permission where possible, with management agreement and according to our sharing protocol guidelines.