# IMHA referral form

## For referrals from professionals

#### *Text field boxes will expand as you type.*

#### *All data supplied to us in this form will be processed in accordance with our* [*Privacy Notice*](https://www.voiceability.org/privacy-policy/)*.*

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| 1. Reason for IMHA referral | | | | |
| **Which of the following applies?***(i) An IMHA is available to a person only when one of the following applies.* | | | | |
| The person is detained under section |  | | *(i) IMHAs are available to anyone detained under the Mental Health Act (even if on leave of absence from the hospital) EXCEPT people under certain short term sections: 4, 5, 135 and 136* | |
| Section the person is detained under: | | |
| Date of detention:  Date admitted if in hospital: | | | *(i) We need to know the date a person has been sectioned as we may need to respond within a certain timeframe* | |
| The person is subject to a Community Treatment Order (CTO) | |  | The person is being considered for S57 treatment |  |
| The person is subject to guardianship | |  | The person is being considered for Electro-Convulsive Therapy |  |
| The person is being considered for S58A treatment | |  | The person is an informal patient on a mental health ward |  |
| The person is a conditionally discharged patient | |  |  |  |
| **Further details about the reason for the referral** | | | | |

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| **2. Details of the person you’re referring** | | | | | | | | | |
| **First name** |  | | | **Last name** |  | | | | |
| **Date of birth** |  | | | | | | | | |
| **Current address and postcode**  *(if hospital, please include ward name; if prison please include wing)* |  | | | | | | | | |
| **Home address and postcode** *(if different to current address)* |  | | | | | | | | |
| **Email** |  | | | | | | | | |
| **Phone number** |  | | | | | | | | |
| **What conditions or disabilities does the person you’re referring have?** *(Please select all that apply)* | | | | | | | | | |
| Learning disability | |  | | Sensory impairment | | | |  | |
| Acquired brain injury | |  | | Long term health condition | | | |  | |
| Autistic spectrum diagnosis | |  | | Substance misuse/addiction | | | |  | |
| Dementia | |  | | Physical disability | | | |  | |
| Neurological conditions | |  | | None | | | |  | |
| Stroke | |  | | Other *(please specify)*  Further details | | | | | |
| Mental health condition | |  | |
| **Does the person have any access needs, for example communication or physical needs?** *(Please select all that apply)* | | | | | | | | | |
| They need an interpreter | | |  | They have physical access needs | | | | |  |
| They use Makaton | | |  | They do not use the telephone | | | | |  |
| They use British Sign Language (BSL) | | |  | They prefer information written down | | | | |  |
| They use assistive communication (e.g. Symbol book, Talking Mats, PECS) | | |  | Other *(please specify)* | | | | | |
| They are non-verbal | | |  | Further details | | | | | |
| They prefer information in Easy Read | | |  |  | | | | | |
| **Has the person you’re referring requested an advocate?** | | | | Yes  No | | | | | |
| **If yes, do they require a same-gender advocate?**  *(i) We always try to meet same-gender requests but are not always able to do this, depending on availability.* | | | | | | Yes  No  Don’t know | | | |
| **Has the person agreed to this referral?**  *(i) If capacity fluctuates then they should be asked about agreeing to a referral when they have capacity* | | | | | | Yes  No  Lacks capacity | | | |
| **What meetings does the advocate need to attend?**  *(i) Please provide the title of the meeting and the date. You can add multiple meetings.*  **Names and dates of meetings** | | | | | | | | | |
| **Is there anything we need to know in order to ensure the safety of the person you are referring and of our advocates?** *(Please select all that apply)* | | | | | | | | | |
| 2 to 1 or higher support ratio | |  | | Other *(please specify)* | | |  | | |
| Daily change in risk profile | |  | | Further details | | | | | |
| History of abuse/​assault of professionals | |  | |
| **If your organisation has a reference number for the person, you must provide it here**  *(i) For example, Mosaic, Care Direct, NHS or prison number* | | | |  | | | | | |
| ***For referrals to our Coventry and Warwickshire team only*** If you are referring someone who does not live in Coventry or Warwickshire but is registered at a GP surgery in Coventry or Warwickshire, please tick here:  Coventry GP  Warwickshire GP | | | | | | | | | |

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| Diversity monitoring | | | | |
| *We want to make sure that our services are reaching everyone who needs them. By giving us the information below about the person you’re referring, you can help us improve what we offer.* | | | | |
| What is the gender of the person you’re referring? | | | Is this different from their gender assigned at birth? | |
| Male |  | | Yes |  |
| Female |  | | No |  |
| Non-binary |  | | Don’t know/prefer not to say |  |
| Other |  | |  |  |
| Don’t know/prefer not to say |  | |  |  |
| What is their sexual orientation? | | | | |
| Heterosexual/​straight |  | | Gay woman/​lesbian |  |
| Bisexual |  | | Don’t know/​prefer not to say |  |
| Gay man |  | | They prefer to self-describe *(please specify)* |  |
| **What is their ethnic group?** | | | | |
| *Asian or Asian British* | | | | |
| Bangladeshi | |  | Pakistani |  |
| Chinese | |  | Another Asian background |  |
| Indian | |  | Don’t know/​prefer not to say |  |
| *Black, African, Black British or Caribbean* | | | | |
| African | |  | Another Black background |  |
| Caribbean | |  | Don’t know/​prefer not to say |  |
| *Mixed or multiple ethnic groups* | | | | |
| Asian and White | |  | Another Mixed background |  |
| Black African and White | |  | Don’t know/​prefer not to say |  |
| Black Caribbean and White | |  |  |  |
| *White* | | | | |
| British, English, Northern Irish, Scottish, or Welsh | |  | Another White background |  |
| Irish | |  | Don’t know/​prefer not to say |  |
| Irish Traveller or Gypsy | |  |  |  |
| *Another ethnic group* | | | | |
| Arab | | |  | |
| Another ethnic background | | |  | |
| Prefer not to say | | |  | |
| Don’t know/​prefer not to say | | |  |  |
| **What is their religion?** | | | | |
| No religion | |  | Christian (all denominations) |  |
| Buddhist | |  | Hindu |  |
| Jewish | |  | Muslim |  |
| Sikh | |  | Other (please state) | |
| Don’t know/​prefer not to say | |  |  | |

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| **3. Your details** | | | | | | |
| **Title** | |  | | | | |
| **Full name** | |  | | | | |
| **Email address** | |  | | | | |
| **Organisation** | |  | | | | |
| **Work address** | |  | | | | |
| **Team or department** | |  | | | | |
| **Profession** | | Doctor |  | Nurse | |  |
| Dentist |  | Other health professional | |  |
| Support worker |  | Social worker | |  |
| Lawyer |  | Manager | |  |
| Police |  | Other | |  |
| **Job title (if different)** | |  | | | | |
| **Phone number we can contact you on** | |  | | | | |
| **Mobile phone number (if different)** | |  | | | | |
| **Would you like to join our email newsletter?** | | Yes, please add my email to the mailing list  No, I’d prefer not to be added to the mailing list | | | | |
| **Is this the first time you have made a referral to VoiceAbility?** | | Yes  No | | | | |
| **If yes, please tell us how you heard about us.** *(Please select all that apply)* | | | | | | |
| Word of mouth |  | | Social media | |  | |
| Online search |  | | Presentation/​training | |  | |
| Leaflet or poster |  | |  | |  | |
| Other (please specify) |  | | | | | |

**Please email the completed form to** [**helpline@voiceability.org**](mailto:helpline@voiceability.org)**.**

If you are emailing this form from Warwickshire, Coventry or a prison in Doncaster, you must email using an approved secure method. For more information, go to   
[**voiceability.org/about-advocacy/advocacy-referral-forms**](http://www.voiceability.org/about-advocacy/advocacy-referral-forms)

**Alternatively, you can post the form to VoiceAbility, c/​o Sayer Vincent, Invicta House, 108-114 Golden Lane, London, EC1Y 0TL.**

If you have a FACE Risk document for the person you are referring, please enclose this along with the referral form.