Swindon Advocacy Movement
Sanford House
Sanford Street
Swindon
SN1 1HE

Swindon Advocacy Movement

IMCA Services Referral Form

Swindon Advocacy IMCA service represents and supports individuals in Swindon who meet the following criteria:

The client referred has no appropriate family or friends to represent them and the referrer has assessed that they lack the capacity, decision specific, concerning:

- **Serious medical treatment OR**
- **Long term accommodation moves (more than 28 days in hospital/8 weeks in a care home)**

Please complete all sections of the referral, Failure to do so may results in a delay.

Client Details

Name:	**Known as:**	**Date of Birth:**

Home Address **Postcode:** **Tel No:**	**Current location of client: (in not at home address)** **Postcode:** **Tel No:**
Nature of client's condition (please tick one or more as appropriate) ☐ Learning Disability ☐ Mental Illness ☐ Dementia ☐ Aging (Over 60) ☐ Serious Physical Illness ☐ Acquired Brain Injury ☐ Autistic Spectrum Disorder ☐ Other, please specify	**Preferred Communication method (please indicate and give brief details as appropriate)** ☐ English ☐ Other spoken language ☐ Pictures/symbols/Makaton ☐ British Sign Language ☐ No Obvious communication ☐ Gestures/vocalisations/facial expressions ☐ Other, please specify

CAPACITY ASSESSMENT – we can only accept an IMCA referral when a recent (within the last year), decision specific, capacity assessment has taken place *AND A COPY IS RETURNED WITH THIS REFERRAL FORM.* In exceptional circumstances Swindon Advocacy Movement may consider older evidence if the rationale is clearly identified.

Has this client been formally assessed to lack capacity? Yes/No

A decision specific capacity assessment was completed on …… / …… /….

Name & Job Title of Assessor:

DECISION TO BE MADE:

- ☐ Serious Medical Treatment
- ☐ Change in Accommodation
- ☐ Safeguarding – (For alleged perpetrator without capacity only)

Has a Local Authority Section 42 enquiry been opened? Yes/No*

*If not then we are unable to provide our advocacy service

Please provide details:

Who is the decision maker?

The decision maker is the individual within either the local authority or the NHS body who has the responsibility for making he decision on issues of change of accommodation or serious medical treatment on behalf of the client who has been assessed as lacking capacity on either issue. A third party can make the referral if they have permission of the decision maker to do so.

DECISION-MAKER Details (if different from the Referrer) Required for Change of Accommodation or Serious Medical Treatment

Decision - Maker Details	
Name:	**Position**
Email	**Telephone Number/Mobile**
Address **Postcode:**	
Does the client have family or close friends appropriate to consult with? Yes/No	
If there are family or friends why is an IMCA needed?	
Please provide names and contact details of anyone else who can help form a true picture of the client's wishes and feelings:	

Referrer Details	
Referral Name:	**Position:**
Telephone/Mobile No:	**Email:**
Team/Department:	**Agency or Provider**

Risk Assessment: Please complete:
This section needs to be completed for us to provide a service to the client. Failure to complete may result in delaying the appointment of an advocate. Please indicate below anything in the clients history or health needs which may give rise to potential risks or dangers either to themselves or to others. Please be aware, advocates are lone workers who often visit clients at home
Any know mental health issues:
Any behaviours we need to know about:
Any know risks in lone working/visiting at home ie friends, family, history etc:
Any particular health needs ie Epilepsy, Asthma etc:
Please give details of any important deadlines or meeting dates: **Person to contract to arrange meeting with client:**

In accordance with Data Protection Act 1998, all information provided on the referral form and in any further dealings with Swindon Advocacy Movement will be treated as confidential and will not be disclosed to any third party without express consent from the client

Would you like to go on our mails for AGM etc Yes/No

Signed Client:	**Date:**
Signed Referrer:	**Date:**

"Swindon Advocacy Movement is committed to safeguarding and promoting the welfare of children, young people and adults. Swindon Advocacy Movement expects all staff and volunteers to share that commitment"

Please send the above referral to: Swindon Advocacy Movement, Sanford House, Sanford Street, Swindon, SN1 1HE. Telephone Number 01793 542575/542266

Email: secure@swindonadvocacy.co.uk

****Referral Receipt**** **SAM will confirm receipt of all referrals within 24 hours Monday – Friday. Please contact SAM if you have not received confirmation of receipt.**

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Telephone on 01793 542575

EQUALITY AND DIVERSITY MONITORING FORM

Swindon Advocacy Movement is committed to encouraging equality, diversity and inclusion among our workforce, volunteers and clients eliminating unlawful discrimination.

In order to ensure the continued development of our Equality, Diversity and Inclusion Policy all Clients are asked to complete the details below. The information will be used solely for monitoring purposes and will be treated as confidential.

Client Details							
Are you Married or in a Civil Partnership			**Yes**		**No**		**Prefer not to say**
Gender:	**Male**		**Female**		**Transgender**		**Prefer not to say**
Sexual Orientation:	**Heterosexual**		**Gay man**	**Gay woman/ Lesbian**		**Bisexual**	**Prefer not to say**
Religion:	**Christian**	**Muslim**		**None**	**Buddist**		**Jewish**
	Sikh	**Hindu**		**Other (please state)**			**Prefer not to say**
Employment Status:	**Employed**	**Unemployed**	**Registered Disabled**		**Retired**	**Student**	**Prefer not to say**
Age Groups	**Under 16**	**16- 24**	**25-34**	**35-44**	**45-54**	**55-64**	**65+**	**Prefer not to say**
Post Code:					**Prefer not to say**		

Ethnicity:			
White British		**Asian – British or Indian**	
White Irish		**Asian – British or Pakistani**	
White Other		**Asian – British or Bangladeshi**	
Please specify;		**Any other Asian background**	
Mixed – White & Black Caribbean		**Black – British or Black Caribbean**	
Mixed – White & Black African		**Black – British or Black African**	
Mixed –White & Asian		**Other Black**	
Mixed – White Other		**Oriental - Chinese**	
Any other mixed background		**Oriental – Other**	
Prefer not to say		**Not Established**	

Disability:					
Do you consider yourself to have any long-standing illness or disability that affects your daily activities or the work that you do? **Please tick**					
Yes		**No**		**Prefer not to say**	
If you have answered yes to the question above, how would you best describe your disability. **Please tick all that apply**					
Hearing		**Speech**		**Physical**	
Visual		**Mobility**		**Learning**	

Mental Health							
Other							