**IMHA Referral Form**

#### *Data supplied to us in this form will be processed in accordance with our Data Protection Policy.*

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| Details of Individual being referred:  |
| **Date:** |  |
| **Client name:**  |  |
| **Date of birth:**  |  |
| **Permanent address:****Postcode:****Telephone number:** |  |
| **Hospital ward**  | Orchard / Beech / Cedar / or detail specific ward in General Hospital / Care Home |
| **Formal diagnosis** |  |
| **Responsible clinician – Name, email & tel. no** |  |
| **Which Article of the Mental Health Law applies** | 21 22 24 30 62 63 64 (spell out) |
|  **OR** |  |
| **If not currently in hospital which issue applies?** | Leave of absence in the community / Medication / Community support package / Formal complaint |
| **If being taken to court, please state which court?** | Royal / Magistrates / Family |

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| Specific Cultural & Communication Needs?  |

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| --- | --- |
| [ ]  Language[ ]  Speech  | [ ]  Hearing[ ]  Learning Disability[ ]  Other (please state)  |

SpecifSpecific Cultural & Communication Needs?

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| Are there any risk issues or incidents the Advocacy service should be aware of? Please detail.  |

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| **Does the individual have any upcoming meetings?**For example, tribunals, manager’s hearings, etc. Please provide dates & times if you are aware of these |  |

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| --- | --- | --- |
| **Does the individual have capacity to consent to the referral?** | Yes [ ]  | No [ ]  |
| **If yes, has consent been obtained?** | Yes [ ]  | No [ ]  |
| **Signature: Date:** |  |  |

**CONFIDENTIAL – Please email completed form to Patricia Winchester:** **patricia@myvoice.org.je**