**Independent Mental Health Advocate (IMHA)**

**Community Advocacy - Referral Form**

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

|  |
| --- |
| Details of Individual being referred:  |
| **Date:** |  |
| **Name:**  |  |
| **Date of birth:**  |  |
| **Permanent address:** |  |
| **Postcode:** |  |
| **Telephone number:** |  |
| **Formal diagnosis:** |  |
| **Responsible Clinician:** | Name:Position:Email:Tel no:  |

|  |  |
| --- | --- |
| Which service is the Individual being seen by, if any? |  |

|  |  |
| --- | --- |
| [ ]  CAMHS[ ]  Adult Mental Health Services[ ]  Older Adult Mental Health Services |  |

Spe

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| --- |
| Any specific cultural & communication needs?  |

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

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| Reason for referral?  |

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| --- | --- |
|  |  |

ifSpecific Cultural & Communication Needs?

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| Any there any risk issues or incidents the Advocacy service should be aware of?   |

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| --- | --- |
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| Does the individual have any upcoming meetings?Please provide dates & times if you are aware of these  |

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

|  |
| --- |
| Signature  |
| Signature:  |  | Date: |  |
| Print Name: |  | Relationship to Individual: |  |

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