**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 |  |

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

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

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| --- |
| Reason for referral? |

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

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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| 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**](mailto:patricia@myvoice.org.je)