**Tameside, Stockport & Oldham**  
**Independent Mental Capacity**

**Advocate (IMCA)**

**Referral Form**

Please complete this form and return by **email** to: [tsoimca@together-uk.org](mailto:tsoimca@together-uk.org)

Referral hotline: **07545207791**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name of the person being referred**  (also give familiar name if different) | | | |  |  |  |
| **Current Location**  (also give previous location if applicable) | | |  |  | | |
| **Tel number:** | |  |  |  | | |
| **Date of birth:** | |  |  |  | | |
| **Date of referral:** | |  |  |  | | |
|  |  |  |  |  |  |  |
| **Name of Referrer:** | | |  |  | | |
| **Job Title & Team:** | |  |  |  | | |
| **Tel number & Email :** | |  |  |  | | |
| **Address :** | |  |  |  | | |
|  | |  |  |  | | |
| **Name of ‘Decision Maker’ (if different from referrer)** | | |  |  | | |
| **Job title:** | | |  |  | | |
| **Tel number & Email:** | |  |  |  | | |
| **Address:** | |  |  |  | | |
|  | |  |  |

**DECISION TYPE** (please tick ONE only)

|  |  |  |  |
| --- | --- | --- | --- |
| Serious Medical Treatment | Change of  Accommodation | Adult  Safeguarding | Accommodation Review |

**DECISION-SPECIFIC CAPACITY**

**Has decision-specific capacity for the above decision been assessed? YES / NO**

|  |  |
| --- | --- |
| **Date of Capacity**  **Assessment:** | **Name and Role**  **of Assessor:** |

**APPROPRIATE FAMILY OR CLOSE FRIENDS**

**Are there any appropriate family or friends available to be consulted on the decision?**

**YES / NO**

|  |
| --- |
| **If they are not appropriate, please explain why they are not:**  (Please note paragraph 10.79 of the MCA Code of Practice states that people simply disagreeing with decision makers does not make them inappropriate to be consulted.) |

**Please describe the decision that the IMCA Service is being consulted on:**

(Please also give any details of timescales involved. You should also send any other relevant documentation eg. minutes of previous meetings etc, which the IMCA is entitled to receive (ref. MCA Section 35(6))

**Reason for person’s lack of capacity:** (please tick)

|  |  |  |  |
| --- | --- | --- | --- |
| **Learning disability** | **Mental health problem** | **Brain injury** | **Dementia** |
| **Other: (please give details)** | | | |

**Please give details of any specific needs the person has, such as the communication methods they use, access issues etc:**

**Please provide details of any potential risk to the individual or Advocate in a one-to-one meeting:**

**This Service is provided by Together: for Mental Wellbeing, 12 Old Street, London EC1V 9BE 020 7780 7300** [**www.together-uk.org**](http://www.together-uk.org) **Registered charity no 211091. Complaints Procedure: By telephone 07834526162 or in writing to Ben Robinson, Together Advocacy Service, Ashworth Hospital, Maghull, Liverpool, L31 1HW**