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| **Independent Mental Health Act Advocacy**  **Referral Form**  To support qualifying patients to understand the legal provisions to which they are subject under the Mental Health Act 1983, to understand the rights and safeguards they are entitled to and to exercise their rights through supporting their participation in decision-making.  Referrals can be made by the person themselves, their nearest relative or by an approved mental health professional or representative of the detaining authority. |  |

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| 1. **Eligibility** | | | | | | | | | | | | | |
| **Qualifying patients are:**   1. *Those detained under the 1983 Mental Health Act (even if on leave of absence) apart from those detained under sections 4, 5(2), 5(4), 135 or 136.* 2. *Conditionally discharged restricted patients.* 3. *Subject to guardianship.* 4. *Under supervised community treatment order (CTO).* 5. *Those being considered for a treatment to which the Mental Health Act section 5 applies (treatments requiring consent and a second opinion).* 6. *Liable to be detained under the act, even if not actually detained, including those who are currently on leave of absence from the hospital or absent without leave, or those for whom an application or court order for admission has been completed.* 7. *Under 18 and being considered for electro-convulsive therapy (ECT) or any other treatment to which section 58A applies (treatments requiring consent or a second opinion).* | | | | | | | | | | | | | |
| 1. **About the person requiring support** | | | | | | | | | | | | | |
| **Mrs/ Mrs:** | | | **Name:** | | | | | | | | **Date of birth:** | | |
| **Tel:** | | | **Email:** | | | | | | | | **Mobile:** | | |
| **First line of Home Address:**  **Postcode:** | | | | | | | | | | | | | |
| **Current Address if different from above:** (Please include ward number)  **Postcode:** | | | | | | | | | | | | | |
| 1. **How does this person communicate?** | | | | | | | | | | | | | |
| Preferred Language: | | | | | | | | Dialect: | | | | | |
| Spoken Language | | | | | | |  | Words/Pictures/Makaton | | | |  | |
| British Sign Language | | | | | | |  | Gestures/Facial Expressions/Vocalisations | | | |  | |
| Other, please give details: | | | | | | | | | | | | | |
| **Known risks (to themselves or others):** Please include if the person is currently on a Covid positive ward, any historical risks, etc | | | | | | | | | | | | | |
| 1. **What are the person’s additional support needs?** | | | | | | | | | | | | | |
| Mental Health Problems | | | | | | |  | Physical Health | | | |  | |
| Cognitive Impairment | | | | | | |  | Autism Spectrum Condition | | | |  | |
| Learning Disability | | | | | | |  | Serious Physical illness | | | |  | |
| Other: | | | | | | | | | | | | | |
| 1. **What care and treatment issue does the person require support with? (Please tick)** | | | | | | | | | | | | | |
| Information about rights under section | | | | |  | Review meeting | | |  | Care and treatment support | | |  |
| Appeal section | | | | |  | Ward/ MDM Meeting support | | |  | Other: | | | |
| What section of the MH Act is the person under? | | | | | | | |  | | | | | |
| Is the person subject to: | | | | | | | | | | | | | |
| Community Treatment Order |  | | | Please provide information: | | | | | | | | | |
| Guardianship |  | | | Please provide information: | | | | | | | | | |
| Section Start Date: | |  | | | | | | Section End Date: | | |  | | |
| Has an appeal or Tribunal been applied for? | | | | | | | | Date the Appeal/ Tribunal is happening: | | | | | |
| 1. **Additional Information** | | | | | | | | | | | | | |
| **What steps need to be taken to maximise the person’s full participation? e.g., consideration of**:  Mental capacity, sensory needs, autism related needs, confidence, information and advice or communication aids, interpreters, time of day, medication effects, suitable environment etc…. | | | | | | | | | | | | | |
| **Is there any other additional information you believe is relevant to this referral?** | | | | | | | | | | | | | |

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| 1. **Diversity Monitoring** | | | | | |
| **By completing the information below you can help us ensure our services reach everyone who needs them and inform how we might improve our service provision.** | | | | | |
| **What is the person’s gender?** | | | | **Is the person’s gender different from that assigned at birth?** | |
| Male | | |  | Yes |  |
| Female | | |  | No |  |
| Non-binary | | |  | Don’t know/prefer not to say |  |
| Don’t know/prefer not to say | | |  |  |  |
| Person’s own description: | | | |  |  |
| **What is the person’s sexual orientation?** | | | | | |
| Heterosexual/straight | | |  | Gay woman/lesbian |  |
| Bisexual | | |  | Don’t know/prefer not to say |  |
| Gay man | | |  | Person’s own description: | |
| **What is the person’s ethnic group?** | | | | | |
| *Asian or Asian British* | | | | | |
| Bangladeshi | | |  | Pakistani |  |
| Chinese | | |  | Another Asian background |  |
| Indian | | |  | Don’t know/prefer not to say |  |
| *Black, African, Black British or Caribbean* | | | | | |
| African | | |  | Another black background |  |
| Caribbean | | |  | Don’t know/prefer not to say |  |
| *Mixed or multiple ethnic groups* | | | | | |
| Asian and White | | |  | Another Mixed background |  |
| Black African and White | | |  | Don’t know/prefer not to say |  |
| Black Caribbean and White | | |  |  |  |
| *White* | | | | | |
| English/Welsh/Scottish/Northern Irish/British | | |  | Another White background |  |
| Irish | | |  | Don’t know/prefer not to say |  |
| Irish Traveller or Gypsy | | |  |  |  |
| *Another ethnic group* | | | | | |
| Arab | | |  | Don’t know/prefer not to say |  |
| Another ethnic background | | |  | Person’s own description: | |
| **What is the person’s religion?** | | | | | |
| No religion | | |  | Hindu |  |
| Christian (all denominations) | | |  | Muslim |  |
| Buddhist | | |  | Other (please state) |  |
| Jewish | | |  | Don’t know/prefer not to say |  |
| Sikh | | |  | Person’s own description: | |
| **Does the person identify as having a disability or long-term health condition?** | | | | | |
| Yes | No | Please specify: | | | |

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| 1. **Referrer Contact Details** | | |
| Name of referrer: | Job Title: | |
| Team: | Organisation: | |
| Email: | Tel: | |
| Date of referral: | How did you hear about us | |
| 1. **Capacity** | | |
| Does this person have capacity around the referring issue? | Yes  No  Fluctuating | |
| \*Can the individual consent to this referral and information being shared? | Yes  No | |
| *\*NB check local policies before sharing this information, regarding GDPR/Consent and information sharing* | | |
| **Disclaimer** | | |
| **Please note that we may not be able to attend all meetings listed on the referral form. Where possible, provide us with 2 weeks-notice for any meetings to allow the advocate adequate time to support the advocacy partner.** | | |
| **The referrer is responsible for providing ASIST with accurate, up to date information and contact details, and updating ASIST with any new information or, amendments to information provided on the referral form after it has been submitted. PLEASE make sure information is correct before submitting this form.** | | |
| **To discuss a referral please contact Asist on 01782 845584**  **Fill in this form and send to Asist by emailing** [**referrals@asist.co.uk**](mailto:referrals@asist.co.uk)  **Head Office: Asist, Winton House, Stoke Road, Stoke-on-Trent, ST4 2RW.** | | |

Service available Monday to Friday 9am to 5pm (excluding bank holidays)

