

Hartlepool Advocacy Hub
Referral Form – IMHA
April 2021

GUIDANCE:

Before making a referral to the Advocacy Hub the referrer should:

Discuss this referral to the Advocacy Hub with the patient/individual for the Advocacy Hub to identify an IMHA from the Provider Framework.

Give the patient/individual the opportunity to decide whether to request IMHA support themselves.

Consider referring to the Advocacy Hub if you think the patient/individual may benefit from IMHA support, but is unable, or unlikely to request an IMHA's support themselves.

A referral should **NOT** be made to the Advocacy Hub where the referrer knows, or strongly suspects the patient/individual does not want the support of an IMHA. The involvement of an IMHA does not affect a patient's/individual's right to seek advice from a legal representative, nor does it affect any entitlement to legal aid. The Advocacy Hub is not a substitute for any independent advocacy which already takes place.

Qualifying patients in Hartlepool.

Local Authority commissioners are responsible for ensuring the IMHA services are available for qualifying patients in England.

"In general, the responsible commissioner will be determined on the basis of registration with a GP practice or, where a patient is not registered, their place of residence".
(Independent Mental Health Advocacy Guidance for Commissioners).

A service will be provided to qualifying patients as follows:

- **Those registered with a permanent GP or a permanent address within the Local Authority area.**
- **If the qualifying patient is placed out of the Local Authority area but retains their home address and permanent GP within the Local Authority area, then the Local Authority may provide an IMHA, but reserves the right not to provide the service depending on such things as distance, time and capacity.**

If the referral is a self-referral or from someone/an agency other than the mental health service provider, the IMHA can request, and will be provided with, risk information from the mental health service provider, with the permission of the patient.

All referrals will receive an appropriate response within agreed timeframes (upon receipt of a completed signed Referral Form including Risk Assessment): **NB – we are able to accept referrals directly by Email and 'Anycomms' on advocacyhub@incontrol-able.co.uk**

This form is subject to review to maintain service provision and monitoring.

PLEASE RETURN THE COMPLETED FORM VIA EMAIL (Preferably) OR TO:
Hartlepool Advocacy Hub, c/o Incontrol-able CIC, Dimensional House, 81 Stranton,
Hartlepool TS24 7QT. **Landline:** 01429 555 009 **Mobile:** 07522 866 080

SERVICE USER DETAILS:				
Name:				
Gender:	M	F	O	DOB:
Permanent Address:				
Postcode:			Telephone:	
Current Location:				
Postcode:			Telephone:	
ETHNIC BACKGROUND (Please tick box that applies)				
White British	<input type="checkbox"/>	Black/Black British (African)	<input type="checkbox"/>	
White Irish	<input type="checkbox"/>	Black/Black British (Caribbean)	<input type="checkbox"/>	
White (Other Background)	<input type="checkbox"/>	Black/Black British (Other Background)	<input type="checkbox"/>	
Mixed: White/Black African	<input type="checkbox"/>	Asian/Asian British (Bangladeshi)	<input type="checkbox"/>	
Mixed: White/Black Caribbean	<input type="checkbox"/>	Asian/Asian British (Indian)	<input type="checkbox"/>	
Mixed: White/Asian	<input type="checkbox"/>	Asian/Asian British (Pakistani)	<input type="checkbox"/>	
Mixed: (Other Background)	<input type="checkbox"/>	Asian/Asian British (Other Background)	<input type="checkbox"/>	
Chinese	<input type="checkbox"/>	Other Ethnic Group	<input type="checkbox"/>	
Any identified religious, cultural or spiritual needs?				
Are there any relevant risks that the IMHA should be aware of? (eg: behaviour, security issues, exposure to infection). If yes please give brief details. If yes, please explain, including any risk assessments i.e. FACE:				
REFERRAL DETAILS:				
IS THIS A SELF-REFERRAL?			YES	NO
The IMHA service has a duty to ensure the safety of lone workers. In accordance with the data protection act we reserve the right to speak to and request information from third parties regarding past and current risk. For further information please contact the IMHA service.				
IF THIS IS NOT A SELF-REFERRAL PLEASE PROVIDE DETAILS BELOW:				
Referrer:				
Role:				
Address:				
Postcode:			Telephone:	
Email:			Fax:	

QUALIFYING PATIENTS FOR IMHA – DETAINED PATIENTS:			
Is the person detained under the Mental Health Act?	YES	NO	
Is the person subject to a Community Treatment Order (CTO)?	YES	NO	
Is the person subject to guardianship?	YES	NO	
Please state which section of Mental Health Act:			
Date Section Commenced:			
QUALIFYING PATIENTS FOR IMHA – INFORMAL PATIENTS:			
Is the patient Informal and discussing the possibility of being given section 57 treatment?	YES	NO	
BRIEF DETAILS OF THE SITUATION THAT REQUIRES IMHA INVOLVEMENT:			
ARE THERE ANY DEADLINES OR IMPORTANT MEETING DATES?			
Is this a first referral?	YES	NO	NOT KNOWN
CONTACT DETAILS:			
Care Coordinator:			
Address:			
Postcode:		Telephone:	
Email:		Fax:	
Current GP:			
Address:			
Postcode:		Telephone:	
Email:		Fax:	
If the current GP is temporary please provide contact details of permanent GP: <i>(i.e. due to hospital admission)</i>			
Permanent GP:			
Address:			
Postcode:		Telephone:	
Email:		Fax:	
Responsible Clinician:			
Address:			
Postcode:		Telephone:	
Email:		Fax:	

Nearest Relative:			
Address:			
Postcode:		Telephone:	
Email:		Fax:	
Has the patient been informed a referral is being made to the IMHA service?	YES	NO	
Has the patient consented to the referral to the IMHA service?	YES	NO	
Does the patient have capacity to instruct an IMHA?	YES	NO	
If you have answered NO to any of the above questions please explain, providing details of any capacity assessment:			
Has the patient/individual received Advocacy support before? YES NO <i>(please indicate)</i> If yes, name of Advocate/Provider:			
DECLARATION:			
<p>Because of the General Data Protection Regulations 2018, a signature is needed to say that you agree to the Advocacy Hub securely holding personal information (including the information on this form), on a computer and in a filing system. It is the policy of the Advocacy Hub that all personal data will be held in accordance with the principles and requirements of General Data Protection Regulations 2018 and other relevant legislation, and that procedures will be put in place to ensure the fair processing of data relating to individuals. The Advocacy Hub is a confidential service; you can request further information on confidentiality from ourselves, or the appropriate IMHA service.</p> <p><i>I agree that the Advocacy Hub can securely hold, and put on computer and in a filing system, the information on this form.</i></p>			
MUST BE SIGNED AND DATED.			
SIGNATURE			
DATE			
THE REFERRER (leave blank if signed by Service User) I would like the Advocacy Hub to do this work. They can keep, and put on computer and in a filing system, the information on this form provided to do the work. <i>I am providing this information and asking for this referral in the Patient/Individual's best interests.</i>			
MUST BE SIGNED AND DATED.			
SIGNATURE			
PRINT NAME			
DATE			