**Independent Mental Capacity Advocacy (St Helens)**

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| **Full name:** |  |
| **DOB:**  |  |
| **Permanent address:**  |  |
| **Current location if different from permanent address:** |  |
| **Telephone number:**  |  |
| **Mobile number:** |  |
| **Email address:**  |  |
| **Disability or impairment:**  | [ ]  Learning disability[ ]  Acquired brain injury [ ]  Autistic spectrum disorder[ ]  Dementia[ ]  Neurological conditions[ ]  Stroke[ ]  Mental health condition [ ]  Sensory impairment [ ]  Long term health condition [ ]  Physical disability [ ]  None [ ]  Not listed, **please specify:**[ ]  Prefer not to say |
| **Gender:** | [ ]  Female[ ]  Male [ ]  Non-binary[ ]  Not listed, **please specify:**[ ]  Prefer not to say |
| **Pronouns:** | [ ]  He/him [ ]  She/her [ ]  They/them  |
| **Sexual orientation:**  | [ ]  Bisexual[ ]  Heterosexual[ ]  Lesbian or gay[ ]  Not listed, **please specify:** [ ]  Prefer not to say |
| **How does the person communicate?**  | [ ]  English[ ]  Other spoken language, **please specify:** [ ]  British Sign Language[ ]  Words/pictures/Makaton [ ]  Gestures/expressions/vocalisations[ ]  Not listed, **please specify:** [ ]  No obvious means of communication |
| **Ethnic origin:**  | [ ]  Arab/British Arab[ ]  Asian/British Asian [ ]  Black/Black British[ ]  Gypsy/Roma/Traveller[ ]  Mixed heritage[ ]  White British – English, Welsh, Scottish, N. Irish[ ]  White – Irish [ ]  White Other [ ]  Not listed, **please specify:** [ ]  Prefer not to say |
| **Religion or belief:**  | [ ]  Atheist[ ]  Baha’i [ ]  Buddhist [ ]  Christian [ ]  Hindu [ ]  Humanist[ ]  Jewish[ ]  Muslim[ ]  Pagan[ ]  Not listed, **please specify:** [ ]  Prefer not to say[ ]  No religion or belief |
| **Have you or any of your family served in the armed forces?** | [ ]  Yes[ ]  No |

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| **Decision Maker’s contact details:**  |
| Name:  | Role:  |
| Address:  |
| Email: |
| Telephone number:  | Fax:  |

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| **Decision to be made:**  |
| Serious medical treatment: [ ]  | Change of accommodation: [ ]  | Safeguarding adults (for the perpetrator): [ ]  | Care review; of a change of accommodation: [ ]   |
| Please provide further information below:  |

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| **Capacity:**  |
| I have reasonable belief that the person lacks capacity around the decision at this time but may regain capacity in the near future |[ ]  I have reasonable belief that the person lacks capacity around the decision and will do for the foreseeable future |[ ]

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| **Has a capacity assessment been carried out?**  | Yes [ ]  | No [ ]  |
| Outcome of the capacity assessment:  |

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| **Family and friend involvement:**  |
| Is there nobody (other than paid workers) whom the decision-maker considers are willing and appropriate to be consulted about the decision? If you have deemed someone ‘inappropriate to consult’, please provide details of this decision: |

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| **Significant dates:**  |
| When does the decision need to be made:Please provide details for any impending meetings or deadlines:  |

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| **Further relevant information:**  |
| Please provide details:  |

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| **Please provide details of any risk the Independent Mental Capacity Advocate will need to consider:**  |
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**Consent from Referrer:**

Due to GDPR (2018), we need signed authorisation to say that people agree to Advocacy Focus holding personal information (including the information on this form)

The person being referred is deemed to lack capacity; therefore, the referrer must sign to say they are referring and providing information in the person’s best interests, acknowledging that the person referred lacks capacity to make this decision.

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| I would like IMCA to do this work. I am providing this information and asking for this referral in the client’s best interests: |
| **Referrer’s signature:**  |  | Date: |

 **Consent from Decision Maker (if possible):**

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| I am instructing the IMCA service to do this work. They can keep records of the information on this form, and other information provided that is needed to complete this work. I am asking for this referral in the best interests of the person concerned: |
| **Decision Maker’s signature:**  |  | Date: |

**Please note: Before formal instruction is accepted, authorisation will be required from the Decision Maker. If it is not possible for a signature from the Decision Maker to be obtained before submission of this form, the IMCA will contact the Decision Maker directly to seek authorisation.**

**Please email the completed form to: admin@advocacyfocus.org.uk**