**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  Female, Male at birth  Male, Female at birth  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:** |
| Please note that the IMCA provision is for individuals who have no family or friends that can be consulted with in regards to the decision. If the family members or friends disagree with each other, or the decision maker, this does not mean that they are ‘inappropriate to consult’ and a referral for an IMCA is not required.  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**