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

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| **Full name:** |  |
| **DOB:** |  |
| **Permanent address:** |  |
| **Current location if different from permanent address:**  (including ward) |  |
| **Telephone number:** |  |
| **Mobile number:** |  |
| **Email address:** |  |
| **Responsible Clinician:** |  |
| **NHS Number:** |  |
| **Section (including start dates):** |  |
| **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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| **Are there any upcoming meetings?**  (tribunal’s, CPA’s, etc) |  |

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| **What support is required?** |  |

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| **Are there any known risks?** |  |

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| **Consent:** | | |
| Due to GDPR (2018), we need signed authorisation to say that people agree to Advocacy Focus holding their personal information (including the information within this referral)  If the person being referred is deemed to lack capacity, 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 | | |
| **Does the person have capacity to consent to the referral?** | Yes | No |
| **If yes, has consent been obtained?** | Yes | No |
| **Signature:** | | |

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| **If you are referring on behalf of someone else, please provide your details below:** | |
| **Name:** |  |
| **Address:** |  |
| **Telephone:** |  |
| **Signature:** |  |

**Once this form is complete, please email it to: admin@advocacyfocus.org.uk**