SOUTH EAST WALES IMCA REFERRAL FORM

Please return completed form to :
Advocacy Support Cymru, Brook House, 2 Lime Tree Court, Mulberry Drive
Cardiff Gate Business Park, Cardiff CF23 8AB

☎ 029 2054 0444 🖷 029 2073 5620 ✉ info@ascymru.org.uk

Only one decision per form

Reason for referral:

Serious medical treatment ☐

Safeguarding Vulnerable Adults ☐

Move to accommodation:

Deprivation of Liberty Safeguards (DoLS)

39A ☐

39C ☐

39D ☐

- ☐ Relevant Person
- ☐ Relevant Person's Representative
- ☐ Relevant Person and Relevant Person's Representative

Care Review: New ☐ Monitoring ☐

RPR ☐ (Relevant Person Representative)

Are there any family/friends? Yes ☐ No ☐

Have they been informed that an IMCA has been instructed? Yes ☐ No ☐

Are they available/appropriate to consult with Yes ☐ No ☐

Why are they not appropriate to consult with:

Do you consider the person to lack capacity? Yes ☐ No ☐

Has a capacity assessment been completed? Yes ☐ No ☐

Date of Assessment: ..... Name of Assessor: .....

Is the person's capacity likely to change? Yes ☐ No ☐

CLIENT NAME		Male ☐ Female ☐ Date of Birth:	
Current Address (where client is now)		Home Address	
Postcode	Tel	Postcode	Tel

REFERRER	
Name:	Position:
Organisation:	
NHS Request ☐	
Local Authority Request ☐	Email:
Telephone number for confirmation of receipt of referral:	

DECISION MAKER (if not the referrer)	
Name:	Position:
Organisation:	
Address:	
Telephone:	Email:

CONTACT PERSON FOR ACCESS TO RECORDS	
Name:	Position:
Organisation:	
Address:	
Telephone:	Email:

Is the client in:

Hospital ☐ Name of Hospital ..... Ward .....

Independent Hospital ☐ Name of Hospital ..... Ward .....

Residential Home ☐ Nursing Home ☐ EMI Residential Home ☐ EMI Nursing Home ☐

Supportive Living ☐ Care Home ☐ Own Home ☐

Other: .....

Are there any risk issues that the IMCA should be aware of (e.g. risk to lone worker, infection control etc) ?

Client Group

Mental Health ☐ Learning Disability ☐ Older People ☐

PSNI (Physical sensory neurological impairment) ☐ SPI (Serious/severe physical illness) ☐

ASD (Autistic Spectrum Disorder) ☐ Dementia ☐ Combination ☐

Brain Injury ☐ Cognitive Impairment ☐

Other: .....

What is their primary communication method? (please tick the most appropriate box)

English ☐ Welsh ☐ Other spoken language ☐ No obvious means of communication ☐

Words/Pictures/Makaton ☐ Gestures/vocalisations/facial expressions ☐ | Sign language (e.g. BSL) ☐

Sign Supported Makaton ☐

Other: .....

Ethnicity

White British ☐ White Irish ☐ White (other) ☐ Chinese ☐ Caribbean ☐

Black African ☐ Black (other) ☐ Bangladeshi ☐ Indian ☐ Pakistani ☐

Asian (other) ☐ Mixed Race ☐ Other: .....

Known religious/cultural beliefs

Additional Contacts – Relevant people to obtain information from.
Other people involved e.g. friends, family, LPA (Lasting Power of Attorney), GP, care home staff, lead nurse who may be able to indicate the wishes of the person being referred.

Name		Name	
Relationship		Relationship	
Address		Address	
Tel		Tel	

Name		Name	
Relationship		Relationship	
Address		Address	
Tel		Tel	

Case overview:

Is there a date by which the decision must be made? YES ☐ NO ☐

If 'YES', what is the date .....

Is there a deadline for a course of action? (Best interest or MDT meeting outcome) YES ☐ NO ☐

If 'YES', what is the date, time and venue?

Is there a deadline for the required report? YES ☐ NO ☐

If 'YES', what is the deadline date?

Has Serious Medical Treatment in an emergency already been carried out? YES ☐ NO ☐

Details

I confirm that the IMCA has permission to access appropriate medical/social care records

I confirm that I am the Decision Maker/Person appointed by the Decision Maker on behalf of:

NHS body or local authority .....

Name (print) .....

Signature ..... Date .....

For decisions regarding (Client name) _____