Advocacy for patients detained under the Mental Health Act is a statutory right.  
Independent Mental Health Advocates (IMHA) are specially trained professionals who work with eligible qualifying patients.

Please complete the referral form if (*please tick*):

|  |  |
| --- | --- |
|  | You would like to see an Independent Mental Health Advocate (*Self Referral*) … or |
|  | If you would like a patient in your care to see an Independent Mental Health Advocate (*Staff*) |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name of Relevant Person**: |  | | | Date of Birth: | |  |
| Home Address: |  | | | | | |
|  |
| Contact Number: |  | | Is it ok to leave a message? | | |  |  |  |  | | --- | --- | --- | --- | | Yes |  | No |  | | |
| Location or ward of Patient: | |  | | | | |
| Ethnicity (*please tick)*: | | | | | | |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | African |  | Bangladeshi |  | Black British |  | Caribbean |  | | Chinese |  | Indian |  | Other |  | Other Asian |  | | Other Black |  | Other Mixed Black |  | Other White |  | Pakistani |  | | Sri Lankan |  | White & Black Carib. |  | White & Black Asian |  | White British |  | | White Irish |  | Declined |  |  |  |  |  | | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Request for Referral Made By  (*if not by patient*):** | | |  | | | |
| Relationship to Individual: | |  | | | Date of request: |  |
| Address: |  | | | | | |
|  |
| Contact Number: |  | | Email: |  | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| If the referral request is by anyone other than the patient, has the patient agreed to this request: (*please tick*) | |  |  |  |  | | --- | --- | --- | --- | | Yes |  | No |  | |
| If no, has the patient been formally assessed or is it otherwise believed that they lack the mental capacity to consent to the referral being made? (*please tick*) | |  |  |  |  | | --- | --- | --- | --- | | Yes |  | No |  | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Care Programme Approach: | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Yes |  | No |  | Not Known |  | |

|  |  |
| --- | --- |
| Patient is eligible for IMHA referral under: (*please tick appropriate section*): | |
| |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Section: | 2 |  | 3 |  | 37 |  | G/ship |  | SCT/CTO |  | 57/58A |  | | |
| Other: |  |
|  |

|  |
| --- |
| Details of situation that requires IMHA involvement: |
|  |

|  |
| --- |
| Please give details of any risks or behaviours we should be aware of: |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Does the patient have any communication needs? (*please tick*) | |  |  |  |  | | --- | --- | --- | --- | | Yes |  | No |  | |
| If yes, please give more information: | |
|  | |

|  |
| --- |
| Please give details of any deadlines or important meeting dates: |
|  |

**For Office Use Only**

|  |  |
| --- | --- |
| Allocated Date: |  |
| Reference Number: |  |

*In accordance with Data Protection Law, we will only use your personal data for   
those purposes for which you have given your permission. A full copy of our   
Privacy Statement is available at www.mindincroydon.org.uk*