VoiceAbility

IMCA referral form

For referrals from professionals

Text field boxes will expand as you type.

All data supplied to us in this form will be processed in accordance with our Privacy Notice.

1. Reason for IMCA referral			
(i) An IMCA referral MUST be made for decisions about long term accommodation and serious medical treatment. *(i) An IMCA referral MAY be made for a care review following a long-term accommodation decision, or for safeguarding issues. For care reviews or safeguarding issues, people may be eligible for a Care Act advocate instead and a Care Act referral may be more appropriate than an IMCA referral. Please contact us for advice if you are unsure.* *(i) IMCAs do not offer support for financial issues. These may need to be referred to the Court of Protection.*			
1. What is the Best Interest Decision to be made?			
Serious medical treatment	☐	Long term accommodation	☐
Safeguarding adults	☐	Care review	☐
2. Please tell us more about the decision that is being made			
3. What is the deadline for the decision?		Date	
4. Are you the decision maker? *(i) For serious medical treatments, the decision maker can be a GP, dentist or consultant* *(i) For long term accommodation, the decision maker can be a social worker, care coordinator, discharge coordinator or nurse.*		Yes ☐ No ☐ If **Yes**, then skip the next question and go to question 6. If **No,** then carry on to the next question.	
5. Please tell us about the decision maker			
First name		**Last name**	
Email			

Address	
Contact number	
Job role	
I don't know who the decision maker is ☐ *(i) We can process the referral without knowing who the decision maker is, but you will need to tell us before the advocate can start work.*	
6. Does the referred person have any family or friends appropriate to consult?	Yes ☐ No ☐ If **Yes**, then carry on to next question. If **No,** then skip the next question and go straight to question 8.
7. People who have friends or family appropriate to consult are not usually eligible for support from an IMCA. Please tell us why an advocate is still required?	
8. Does the person you're referring have capacity to make the decision you are referring about?	Yes ☐ No ☐ If **Yes**, the person is ineligible for an IMCA. Please call us for further guidance. If you are unsure about their capacity, proceed to the next question.
9. Has a 2-stage functional assessment of capacity been carried out?	Yes ☐ No ☐ If **Yes,** please send us the capacity assessment with this form. If **No**, please send the capacity assessment as soon as you have it.

2. Details of the person you're referring

First name		**Last name**	
Date of birth			
Current address and postcode *(if hospital, please include ward name; if*			

prison please include wing)	
Home address and postcode *(if different to current address)*	
Email	
Phone number	

What conditions or disabilities does the person you're referring have?
(Please select all that apply)

Learning disability	☐	Sensory impairment	☐
Acquired brain injury	☐	Long term health condition	☐
Autistic spectrum diagnosis	☐	Substance misuse/addiction	☐
Dementia	☐	Physical disability	☐
Neurological conditions	☐	None	☐
Stroke	☐	Other *(please specify)*	
Mental health condition	☐	Further details	

Does the person have any access needs, for example communication or physical needs?
(Please select all that apply)

They need an interpreter	☐	They have physical access needs	☐
They use Makaton	☐	They do not use the telephone	☐
They use British Sign Language (BSL)	☐	They prefer information written down	☐
They use assistive communication (e.g. Symbol book, Talking Mats, PECS)	☐	Other *(please specify)*	
They are non-verbal	☐	Further details	
They prefer information in Easy Read	☐		

Has the person you are referring requested an advocate?	Yes ☐ No ☐
If yes, do they require a same-gender advocate? *(i) We always try to meet same-gender requests but are not always able to do this, depending on availability.*	Yes ☐ No ☐ Don't know ☐
Has the person agreed to this referral? *(i) If capacity fluctuates then they should be asked about agreeing to a referral when they have capacity*	Yes ☐ No ☐ Lacks capacity ☐
What meetings does the advocate need to attend? *(i) Please provide the title of the meeting and the date. You can add multiple meetings.* **Names and dates of meetings**	
Is there anything we need to know in order to ensure the safety of the person you are referring and of our advocates? *(Please select all that apply)*	
2 to 1 or higher support ratio ☐ Daily change in risk profile ☐ History of abuse/assault of professionals ☐	Other *(please specify)* Further details
If your organisation has a reference number for the person, you must provide it here *(i) For example, Mosaic, Care Direct, NHS or prison number*	
For referrals to our Coventry and Warwickshire team only If you are referring someone who does not live in Coventry or Warwickshire but is registered at a GP surgery in Coventry or Warwickshire, please tick here: Coventry GP ☐ Warwickshire GP ☐	

Diversity monitoring

We want to make sure that our services are reaching everyone who needs them. By giving us the information below about the person you're referring, you can help us improve what we offer.

What is the gender of the person you're referring?		**Is this different from their gender assigned at birth?**	
Male	☐	Yes	☐
Female	☐	No	☐
Non-binary	☐	Don't know/prefer not to say	☐
Other	☐		
Don't know/prefer not to say	☐		

What is their sexual orientation?			
Heterosexual/straight	☐	Gay woman/lesbian	☐
Bisexual	☐	Don't know/prefer not to say	☐
Gay man	☐	They prefer to self-describe	

What is their ethnic group?			
Asian or Asian British			
Bangladeshi	☐	Pakistani	☐
Chinese	☐	Another Asian background	☐
Indian	☐	Don't know/prefer not to say	☐
Black, African, Black British or Caribbean			
African	☐	Another Black background	☐
Caribbean	☐	Don't know/prefer not to say	☐
Mixed or multiple ethnic groups			
Asian and White	☐	Another Mixed background	☐

Black African and White	☐	Don't know/prefer not to say	☐
Black Caribbean and White	☐		
White			
British, English, Northern Irish,	☐	Another White background	☐
Irish	☐	Don't know/prefer not to say	☐
Irish Traveller or Gypsy	☐		
Another ethnic group			
Arab	☐		
Another ethnic background	☐		
Prefer not to say	☐		
Don't know/prefer not to say	☐		
What is their religion?			
No religion	☐	Christian (all denominations)	☐
Buddhist	☐	Hindu	☐
Jewish	☐	Muslim	☐
Sikh	☐	Other (please state)	
Don't know/prefer not to say	☐		

3. Your details

Title	
Full name	
Email address	
Organisation	
Work address	

Team or department	*(If you work in Warwickshire, this must be with your full team code, e.g. LD North - AC514)*	
Profession	Doctor ☐ Dentist ☐ Support worker ☐ Lawyer ☐ Police ☐	Nurse ☐ Other health ☐ Social worker ☐ Manager ☐ Other
Job title (if different)		
Phone number we can contact you on if we have questions about this referral		
Mobile phone number (if different)		
Would you like to join our email newsletter?	Yes, please add my email to the mailing list ☐ No, I'd prefer not to be added to the mailing list ☐	
Is this the first time you have made a referral to VoiceAbility?	Yes ☐ No ☐	

If yes, please tell us how you heard about us. *(Please select all that apply)*

Word of mouth ☐	Social media ☐
Online search ☐	Presentation/ ☐
Leaflet or poster ☐	
Other (please specify)	

Please email the completed form to helpline@voiceability.org.

If you are emailing this form from Warwickshire, Coventry or Doncaster, you must email using an approved secure method, see: **voiceability.org/about-advocacy/advocacy-referral-forms**

Alternatively, you can post the form to Unit 1, The Old Granary, Westwick, Oakington, Cambridge, CB24 3AR

For referrals from prisons, Health Care Representatives can hand this form in to the Head of Health Care, c/o Health Care Department.