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| **asist logo repro5**  **IMCA referral form** | **Please send the completed IMCA referral form to the following below:** |

**Eligibility Checklist**

Following IMCA decision types:   
(referral must be made by the ***decision-maker***/ someone ***authorised by them***)

NO

Does the person have anyone consultable?  
*(family/friends etc)*

Not eligible for an IMCA.

***2 Stage Capacity Assessment***Has the person been assessed to lack mental capacity specifically in relation to the proposed decision?

YES

NO

YES

**Accommodation Review *(Power to instruct)***Decision about current accommodation

**Serious Medical Treatment *(Duty to instruct)***Provision, withholding or withdrawal of treatment e.g. DNAR

Please complete the attached referral form.

For further information please contact the Asist office.

**Change of Accommodation *(Duty to instruct)***Hospital stay of 28 days or more, care home stay for more than 8 weeks

**Safeguarding of Vulnerable Adults *(Power to instruct)***Irrespective of friends/family in relation to proposed *protective measures*

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| **Name Of Person Referred** |  | | **Date Of Referral** |  | | | |
| **IMCA TEAM AVAILABLE MONDAY – FRIDAY 9am – 5pm  (excluding bank holidays) & will always confirm receipt of a referral within 24 hours** | | | | | | | |
| **Eligibility Criteria please tick as appropriate:** | | | | | | | |
| **Person 16 years or over** |  | **No specific decision making arrangements in place  (e.g. powers of attorney, advance decision)** | | |  | | |
| **Assessed as lacking mental capacity (specific to the decision)** |  | **What date was it completed?** | | |  | | |
| **Who completed this assessment?** | |  | | | | | |
| **What decision was it in relation to?** | |  | | | | | |
| **Please confirm that there are no consultable friends or family** | | | | | |  | |
| **If there are family or friends known, but they are not considered to be consultable please state why:** | | | | | | | |
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| **Decision Type:** | | | | | | | |
| **Serious Medical Treatment decision**  (provision, withholding, withdrawal of treatment e.g. DNAR - do not attempt resuscitation) | | | | | | |  |
| **Change Of Accommodation decision**  (Hospital stay of 28 days or more, nursing/residential stay of 8 weeks or more) | | | | | | |  |
| **Care Reviews.** (Reviews should relate to decisions about accommodation) | | | | | | |  |
| **Safeguarding Adults investigation** (irrespective of friends and family in relation to proposed protective measures) | | | | | | |  |
| **Please provide details of the proposed protective measures:** | | | | | | | |
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| **Client Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Full name of Person Being Referred:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Male** |  | | **Female** | | | |  | **Date of Birth:** | | | | | | | | |  | | | | | | **Age Now:** | | | | | |  | | | | |
| **Current Address:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Postcode:** | | | | | |  | | | | | | | | **Telephone Number:** | | | | | |  | | | | | |
| **Own Home** | |  | | | | **Care Home** | | | | |  | | | | **Health Unit** | | | | |  | | | | **Hospital Other** | | | | | |  | | | |
| **Please tick if there any risks associated with this referral?  (For example: violence or aggression, infectious diseases)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| **If ‘Yes’ please specify:** | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
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| **What ethnicity is this person?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **White:** | | | | | **Asian or**  **Asian British:** | | | | | | | **Mixed:** | | | | | | | | | **Black or**  **Black British:** | | | | | | **Chinese or not established** | | | | | | |
| **British** | | | |  | **Pakistani** | | | |  | | | **White & Black Caribbean** | | | | | |  | | | **Black Caribbean** | | | |  | | **Chinese** | | | | | |  |
| **Irish** | | | |  | **Bangladeshi** | | | |  | | | **White & Black African** | | | | | |  | | | **Black African** | | | |  | | **Ethnicity not established** | | | | | |  |
| **Indian** | | | | | | | | |  | | | **White & Asian** | | | | | |  | | | **Other (specify)** | | | | | | | | | | |  | |
|  | | | | | | | | | | | | |
| **Please tick if there any identified religious, cultural or spiritual needs** | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| **If ‘Yes’ please specify:** | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| **What type of Impairment does this person have?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Mental**  **Health Problems** | | | |  | **Serious**  **Physical Illness** | | | | |  | | **Physical Disability** | | | | | |  | **Cognitive Impairment** | | | | | | |  | | **Acquired**  **Brain Damage** | | | | |  |
| **Dementia** | | | |  | **Autism**  **Spectrum Condition** | | | | |  | | **Learning Disability** | | | | | |  | **Unconscious** | | | | | | |  | | **Other**  **(specify)** | | | | |  |
| **How does this person communicate?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Spoken Language** | | | | | | | | | | | | |  | | | **Gestures / Facial Expressions / Vocalisations** | | | | | | | | | | | | | | | | |  |
| **British Sign Language** | | | | | | | | | | | | |  | | | **Communication method unknown** | | | | | | | | | | | | | | | | |  |
| **Words / Pictures / Makaton** | | | | | | | | | | | | |  | | | **Other** | | | | | | | | | | | | | | | | |  |

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| **Referral Contacts** | | | | | | | | | | | | | | | | |
| **Details of the person making this referral. (Authorised Officer)** | | | | | | | | | | | | | | | | |
| **Name:** | | | | |  | | | | | | | | | | | |
| **Consultant** |  | **Social Care Team Manager** | | |  | | **Doctor** |  | **Social Worker** | | | | |  | **Other – please state:** |  |
|  | |
| **Which organisation do you work for?** | | | | | | | | | | | | | | | | |
| **Independent Futures** | | |  | **South staffs foundation mental health trust** | | | | | | |  | **Staffordshire county council** | | | |  |
| **SSOTP** | | |  | **North staffs combined mental health trust** | | | | | | |  | **Stoke city council** | | | |  |
| **Address:** | | | | |  | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Email:** | | | | |  | | | | | | | | | | | |
| **Telephone:** | | | | |  | | | | | | | | | | | |
| **Same contact details as the:** | | | | | **Client Contact** | | | | |  | | | **Decision-maker** | | |  |
| **Details of the person ultimately responsible for the best-interest decision. (Decision-maker)** | | | | | | | | | | | | | | | | |
| **Name:** | | | | | |  | | | | | | | | | | |
| **Consultant** |  | **Social Care Team Manager** | | | |  | **Doctor** |  | **Social Worker** | | | | |  | **Other – please state:** |  |
|  | |
| **Address:** | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | |
| **Email:** | | | | | |  | | | | | | | | | | |
| **Telephone:** | | | | | |  | | | | | | | | | | |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Same contact details as the:** | **Client Contact** |  | | **Authorised Officer** | |  | | **Details of the person to contact to make visiting arrangements. (Client Contact)** | | | | | | | | **Name:** |  | | | | | | | **Address:** |  | | | | | | |  | | | | | | | **Telephone:** |  | | | | | | | **Same contact details as the:** | **Decision-maker** | |  | **Authorised Officer** |  | | | | | | | | | | | | | | | | | | |

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| **Decision Details** |
| **Please give brief details of the situation surrounding the decision Including brief details of any essential information or special instructions for contacting the partner:** |
|  |
| **Please give details of any specific meetings or deadlines** |
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| * **ASIST provides the IMCA service across Stoke and Staffordshire.** * **All referral should be made by completing the attached form and sending it by fax, e-mail or post.**   **Email:** [**IMCA@asist.co.uk**](mailto:IMCA@asist.co.uk)**, Fax: 01782 746647, Tel: 011782 845584, ASIST, Winton House, Stoke Road, Stoke-on-Trent, Staffs ST4 2RW**   * **During periods of high demand on the IMCA service, Serious Medical Treatment and 39A DoLS referrals will be given priority over Safeguarding referrals and accommodation reviews** | |
| **For further information you can contact Asist, or the Local Authority Adult Protection Co-ordinators at:** | |
| **Peter Hampton,** Adult Protection Co-ordinator, Staffordshire County Council on 01785 895676 peter.hampton@staffordshire.gov.uk | **Jackie Bloxham** Adult Protection Co-ordinator**,** Stoke on Trent City Council on 01782 232396 Jackie.Bloxham@stoke.gov.uk |

What happens next?

We will acknowledge the referral within 24 hours

The referral will then aimed to be allocated to an advocate within 7-14 working days (sooner for SMT decisions).

Advocate will make contact with you/decision maker to arrange an initial visit.

The advocate will make contact with others over telephone email to find out necessary information required. Researches information about the decision itself.

The advocate writes a report, which includes ‘considerations’ that the decision maker may wish to consider before the decision is made.

At the initial visit, advocate will meet with the person and try and establish a view from the person about the decision, read case notes and speak to staff.