# **ASK 4 Advocacy – IMHA Referral Form**

This referral form is for **Independent Mental Health Advocacy**. You can complete this form on your own behalf (self-referral) or on behalf of someone else.

**Incomplete forms may be returned to you - which can result in delay allocating an advocate.**

Referral forms can be emailed via secure email to: advocacy@touchstonesupport.org.uk

If you do not have a secure email system you can password protect the form and send the password in a separate follow-up email.

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| How did you hear about this service? |  | Date of referral |  |

**Referral Information**

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| **Client Details:** (person requiring advocacy) | | | | | | | | | | | | | |
| Name: |  | | | | | | | | | | | | |
| Date of Birth (DD/MM/YY): | | |  | | | | | | | | | | |
| Home Address: | | | | | | C | | | | | | | |
| Postcode: | | | | | | Postcode: | | | | | | | |
| Home tel number: | | | | | | Current tel number: | | | | | | | |
| Can we leave a message? | | | | Yes  x | No | Email: |  | | | | | | |
| Has consent been given to you to make this referral by the person requiring advocacy? If **No** please provide details why: | | | | | | | | | | Yes | x | No |  |
|  | | | | | | | | | | | | | |
| **Referrer Details:** | | | | | | | | | | | | | |
| Name: | |  | | | | | | | | | | | |
| Role / Job Title: | |  | | | | | | | | | | | |
| Organisation: | |  | | | | | | | | | | | |
| Place of work:  (ward / unit / team - including address) | |  | | | | | | | | | | | |
| Phone Number: | |  | | | | | | Mobile: |  | | | | |
| Email Address: | |  | | | | | | Secure email: |  | | | | |

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| **Is the person detained under a section of the Mental Health Act 1983?** | | | | | Yes | No | |
| **Start date of Section:** | |  | | | | | |
| An informal patient |  | |  | On Supervised Community Treatment Order (SCTO) | | |  |
| Detained on Section 2 |  | |  | On Guardianship | | |  |
| Detained on Section 3 |  | |  | Under 18 & on Section 58 treatment | | |  |
| On Section 57 treatment |  | |  | Other (*please state below*): | | |  |
|  | | | | | | | |
| **I would like help with:** | | | | | | | |
| Ward Rounds / CPA |  | |  | Understanding my rights | | |  |
| Leave from hospital |  | |  | Accessing legal advice | | |  |
| Discharge issues |  | |  | Appealing my section | | |  |
| Making a formal complaint |  | |  | Other things (*please state below*): | | |  |
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| **Additional Contacts:** | |
| Name of Responsible Clinician (RC) |  |
| Name of Nearest Relative (NR) |  |
| Contact number for NR |  |
| Relationship of Nearest Relative to the person |  |

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| **Health and Safety:** | | | | |
| Are there any current **Risk Issues** we need to be aware of? If **Yes** please provide details below and risk assessment if available. | Yes |  | No |  |
| |  |  |  |  | | --- | --- | --- | --- | |  | Environment? |  | Behaviour of others? | |  | Animals / Pets? |  | Alcohol or drugs? | |  | Behaviour of relevant person? |  | Other? |   Further Information: | | | | |
| **Please note that risk which is disclosed, or emerges, at a later date may mean that we change the way that we work and that we reserve the right to change the advocate if we believe it to be necessary.** | | | | |

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| **Other relevant information about the person requiring advocacy.** Please select all that apply. | | | | | | |
| Learning Disability |  | | Mental Health Disability | | |  |
| Physical Disability |  | | Sensory Disability | | |  |
| Long Term Health Condition |  | | Acquired Brain Injury / Stroke | | |  |
| Autistic Spectrum Disorder |  | | Dementia | | |  |
| Cognitive Impairment |  | | None | | |  |
| Other (please state): |  | | | | | |
| Prefer not to say |  | | Not Asked | | |  |
| **Please state how the person requiring advocacy communicates.** *Please select all that apply.* | | | | | | |
| British Sign Language (BSL) |  | Gestures |  | Verbally |  | |
| Cue Cards |  | Makaton |  | Writing |  | |
| First Language (please state) |  |  | | Other (please state) |  | |

**Monitoring:**

The following information is collected to help us create equal opportunities for individual’s resident within our local communities. We use this information anonymously to identify if the diversity of the people accessing our services fully reflects the communities we serve. When it doesn’t this information helps us to make new links with services and organisations, support equality and diversity and promote equal access to our services.

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|  | **Ethnicity** | | |
| White: British |  | Asian/Asian British: Bangladeshi |  |
| White: English |  | Asian/Asian British: Indian |  |
| White: Scottish |  | Asian/Asian British: Pakistani |  |
| White: Welsh |  | Asian/ Asian British: Kashmiri |  |
| White: Irish |  | Asian/Asian British: Chinese |  |
| White: Northern Irish |  | Asian/Asian British: Other |  |
| White: Other |  | Mixed: White/Black African |  |
| Black/Black British: African |  | Mixed: White/Black Caribbean |  |
| Black/Black British: Caribbean |  | Mixed: White/Asian |  |
| Black/Black British: Other |  | Mixed: Other |  |
| Other: Arab |  | Other: Gypsy / Traveller |  |
| Other: Any Other Ethnic Background  (please state) |  | | |
| Prefer not to say |  | Not asked |  |

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| **Religion** | | | | |
| Buddhist |  | Muslim | |  |
| Christian |  | Sikh | |  |
| Hindu |  | Jewish | |  |
| No Religion |  | No Belief | |  |
| Other (please state) |  | | Prefer not to say |  |

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| **Gender** | | | | | | |
| Woman |  | Man |  |  | Non-binary |  |
| Trans Woman |  | Trans Man |  |  | Prefer not to say |  |
| Other (please state) |  |  |  | | Not asked |  |

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| **Sexuality** | | | | | |
| Heterosexual |  | Lesbian / Gay Woman |  | Gay Man |  |
| Bisexual |  | Prefer not to say |  | Not Asked |  |
| Other (please state) |  | | | | |

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| **Ex-Service Personnel** | | | | | | |
| No |  | Yes (Spouse) |  |  | Prefer not to say |  |
| Yes (Self) |  | Yes (Dependent) |  |  |  |  |

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