**Independent Mental Health Advocacy Referral Form**

To support qualifying patients to understand the legal provisions to which they are subject to under the Mental Health Act 1983, to understand the rights and safeguards they are entitled to and to exercise their rights through supporting their participation in decision-making.

Please ensure you compete this form fully. If the form is not fully completed, this may cause a delay in the allocation of an advocate.

**ABOUT THE PERSON YOU ARE REFERRING:**

|  |  |
| --- | --- |
| **Full Name** |  |
| **Date of Birth** |  |
| **Permanent Address** |  |
| **Postcode** |  |
| **Current Address** (if different) |  |
| **Postcode** |  |
| **Phone number(s)** |  |
| **Email address** |  |
| **Disability or impairment** | Learning disability  Mental health condition  Cognitive impairment  Physical health  Autistic spectrum disorder  Serious physical illness |
| **Gender** | Female  Male  Female, Male at birth  Male, Female at birth  Non-binary  Prefer not to say  Not listed, **please specify**: |
| **Pronouns** | She/her  He/him  They/them |
| **Sexual orientation** | Heterosexual  Bisexual  Lesbian or gay  Prefer not to say  Not listed, **please specify:** |
| **How does the person communicate?** | English  Other spoken language, **please specify:**  British Sign Language  Words/pictures/Makaton  Gestures/expressions/vocalisations  No obvious means of communication  Not listed, **please specify:** |
| **Ethnic origin** | Arab / British Arab  Asian / British Asian  Black / Black British  Gypsy / Roma / Traveller  Mixed heritage  White British – English, Welsh, Scottish, N. Irish  White Irish  White other  Prefer not to say  Not listed, **please specify:** |
| **Religion or belief** | Atheist (no religion)  Christian (all denominations)  Buddhist  Sikh  Hindu  Jewish  Humanist  Pagan  Muslim  Not listed, **please specify:**  Person’s own description: |

**ABOUT YOU:**

|  |  |
| --- | --- |
| **Referrer Details** | |
| Name |  |
| Role |  |
| Team |  |
| Place of work (including address) |  |
| Phone number |  |
| Email address |  |

**REFERRAL INFORMATION:**

|  |  |  |
| --- | --- | --- |
| **What section of the Mental Health Act is the person subject to?** | | |
| **Section start date?** | | |
| Has a Tribunal been applied for? | Yes | No |
| If so, please provide dates: | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Issue/task to be addressed** | | | |
| Information about rights |  | Ward/MDT meeting |  |
| Appeal of section;  Please provide detail of section, including section type and start date |  | Care and treatment support |  |
| Community Treatment Order support and/or review |  | Guardianship |  |
| Other, **please specify:** | | |  |

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| **Further relevant information** |
| Please provide details: |

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| **Significant dates** |
| Please provide details for any impending meetings or deadlines: |

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| **Risk** |
| Are there any risks pertaining to the person? Are there any risks relating to an advocate visiting the person? |
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| --- | --- | --- |
| **Consent** | | |
| Due to GDPR (2018), we need authorisation to say that people agree to Asist holding their personal information included on this form.  If the person being referred is deemed to lack capacity, the referrer must indicate they are referring in the person’s best interest. | | |
| **Does the person have capacity to consent to this referral?** | Yes | No |
| **If yes, has consent been obtained?** | Yes | No |
| **Is the referral being made in best interest?** | Yes | No |

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| **Disclaimer** |
| **Please** note where possible, provide us with 2 weeks’ notice for any meetings to allow the advocate adequate time to support the person being referred. We may not be able to attend all meetings requested. |
| **Please** make sure information on this form is correct before submitting. |

**Please email completed form to: referrals@asist.co.uk**