

## CONFIDENTIAL

First Name:		Surname:	
Date of Birth:			
Home Address & Postcode:			
Current location if different from above <b>(including telephone and ward details)</b>			
Telephone Number:			
Mobile Number:			
Email Address:			
NHS Number:			
Funding Authority:			
Preferred method of contact:	Phone	Email	Post

Does this person have any communication needs?	
<b>Please detail any known risks</b>	

## CONSENT - Advocacy Operates under the GDPR Guidelines

If the person being referred is deemed to lack capacity, please sign below to say that you are referring in the client's best interest

Does the person have capacity to consent to this referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, has consent been obtained?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signature of referrer:	

Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Female, male at birth <input type="checkbox"/> Male, female at birth <input type="checkbox"/> Other, please specify _____ <input type="checkbox"/> Non-binary
Pronouns:	<input type="checkbox"/> He/him <input type="checkbox"/> She/her <input type="checkbox"/> They/them
Sexual Orientation:	<input type="checkbox"/> Asexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay/Lesbian <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Other, please specify _____
Client Group:	<input type="checkbox"/> Acquired brain injury <input type="checkbox"/> Multiple impairments <input type="checkbox"/> Neurological conditions <input type="checkbox"/> Carer <input type="checkbox"/> Older person <input type="checkbox"/> Physical disability <input type="checkbox"/> Dementia <input type="checkbox"/> Sensory impairment <input type="checkbox"/> Stroke <input type="checkbox"/> Long term health condition <input type="checkbox"/> Substance misuse <input type="checkbox"/> Other (please specify) _____ <input type="checkbox"/> Autism <input type="checkbox"/> Learning disability <input type="checkbox"/> Communication difficulties <input type="checkbox"/> Mental health
Disability:	<input type="checkbox"/> Yes <input type="checkbox"/> No Please specify: _____

Ethnic Origin:	<input type="checkbox"/> African	<input type="checkbox"/> Arab/British Arab	<input type="checkbox"/> Asian/British Asian
	<input type="checkbox"/> Black/Black British	<input type="checkbox"/> Carribean	<input type="checkbox"/> Chinese
	<input type="checkbox"/> European	<input type="checkbox"/> Gypsy/Roma	<input type="checkbox"/> Indian
	<input type="checkbox"/> Mixed heritage	<input type="checkbox"/> Pakistani	<input type="checkbox"/> White British
	<input type="checkbox"/> White Irish	<input type="checkbox"/> White other	<input type="checkbox"/> Prefer not to say
	<input type="checkbox"/> Other, please specify: _____		

Religion:	<input type="checkbox"/> Atheist	<input type="checkbox"/> Sikh	<input type="checkbox"/> Not known
	<input type="checkbox"/> Catholic	<input type="checkbox"/> Buddhist	<input type="checkbox"/> No religion
	<input type="checkbox"/> Christian	<input type="checkbox"/> Hindu	<input type="checkbox"/> Other/denomination please specify:
	<input type="checkbox"/> Jewish	<input type="checkbox"/> Muslim	<input type="checkbox"/>
	_____		

Marital Status:	<input type="checkbox"/> Married/Civil Partnership	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced
	<input type="checkbox"/> Separated	<input type="checkbox"/> Living together	<input type="checkbox"/> Widowed
	<input type="checkbox"/> Other, please specify: _____		

### Please provide Referrer and Decision Maker details

	Referrer	Decision Maker
Name:		
Job/Role:		
Organisation/Team:		
Telephone:		
Email:		
Referral Date:		

### Advocacy Service Information

**Independent Mental Health Advocacy (IMHA) - please complete all below sections for us to be able to triage the referral**

Section 2	Section 3	CTO	Guardianship	Other: _____
Section start date:				
Ward:				
Any upcoming meeting dates?				

**REFERRAL REASONS** (Please add any relevant information)

Please return this form to -

Email: [referral@cumberlandimhabub.org.uk](mailto:referral@cumberlandimhabub.org.uk) Phone: 0300 3030 622

Post: Cumbria IMHA Hub, 1 Edward VII Quay, Navigation Way, Preston, PR2 2YF

Website: [www.cumberlandimhabub.org.uk](http://www.cumberlandimhabub.org.uk)