Cumbria IMHA Hub

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CONFIDENTIAL

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

Does this person have any communication needs?	
Please detail any known risks	

CONSENT - Advocacy Operates under the GDPR Guidelines

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

Does the person have capacity to consent to this referral?	☐ Yes ☐ No
If yes, has consent been obtained?	☐ Yes ☐ No
Signature of referrer:	

Gender:	☐ Male ☐ Female, male at birth ☐ Non-binary	☐ Female ☐ Male, female at birth	☐ Prefer not to say ☐ Other, please specify _____
Pronouns:	☐ He/him ☐ She/her ☐ They/them		
Sexual Orientation:	☐ Asexual ☐ Gay/Lesbian	☐ Bisexual ☐ Prefer not to say	☐ Heterosexual ☐ Other, please specify _____
Disability:	☐ Acquired brain injury ☐ Carer ☐ Dementia ☐ Long term health condition ☐ Autism ☐ Communication difficulties	☐ Multiple impairments ☐ Older person ☐ Sensory impairment ☐ Substance misuse ☐ Learning disability ☐ Mental health	☐ Neurological conditions ☐ Physical disability ☐ Stroke ☐ Other (please specify) _____

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Ethnic Origin:	☐ African ☐ Black/Black British ☐ European ☐ Mixed heritage ☐ White Irish ☐ Other, please specify: _____	☐ Arab/British Arab ☐ Carribean ☐ Gypsy/Roma ☐ Pakistani ☐ White other	☐ Asian/British Asian ☐ Chinese ☐ Indian ☐ White British ☐ Prefer not to say

Religion:	☐ Atheist ☐ Catholic ☐ Christian ☐ Jewish	☐ Sikh ☐ Buddhist ☐ Hindu ☐ Muslim	☐ Jehovah Witness ☐ Not known ☐ No religion ☐ Other, please specify: _____

Marital Status:	☐ Married/Civil Partnership ☐ Separated ☐ Other, please specify: _____	☐ Single ☐ Living together	☐ Divorced ☐ Widowed

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?	

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REFERRAL REASONS (Please add any relevant information)

Please return this form to -
Email: **referral@cumbriaimhahub.org.uk** Phone: **0300 3030 622**
Post: **Cumbria IMHA Hub, 1 Edward VII Quay, Navigation Way, Preston, PR2 2YF**
Website: **www.cumbriaimhahub.org.uk**

Cumbria County Council