

CONFIDENTIAL

Client Name:	
Date of Birth:	
NHS Number:	
Home Address & Postcode:	
Funding Local Authority:	
Telephone Number:	
Email Address:	
Present location, postcode, tel. (if different from above) If hospital please include ward number	

CONSENT - Advocacy Operates under the GDPR Guidelines

Has client consented to this referral?	
For statutory: if the client is not able to consent, are you giving us instruction? (IMHA, IMCA, CAA)	

Gender:		Ethnicity:	
Disability:			

Gender Identity:		Marital Status:		Religion:	
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Sexual Orientation:	
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Preferred method of contact: Phone Email Post

Please detail any risks that the client may pose to N-Compass Staff that we should be aware of:

REFERRER DETAILS

DECISION MAKER DETAILS

Name:		
Job/Role:		
Organisation/Team:		
Telephone:		
Email:		
Referral Date:		

ADVOCACY SERVICE INFORMATION

INDEPENDENT MENTAL HEALTH ADVOCACY (IMHA)

Section 2 Section 3 Community Treatment Order Other _____

What ward are they currently on? _____

When did the section begin? _____

GENERIC ADVOCACY

Is the issue regarding health or social care? Yes No

Is this person an informal patient on a psychiatric ward? Yes No

REFERRAL REASON (Please add any Relevant information inc. meeting dates)

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

www.cumbriaimhahub.org.uk