Cumberland 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 below 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 ☐ Prefer not to say ☐ Female, male at birth ☐ Male, female at birth ☐ Other, please specify ☐ Non-binary ____________
Pronouns:	☐ He/him ☐ She/her ☐ They/them
Sexual Orientation:	☐ Asexual ☐ Bisexual ☐ Heterosexual ☐ Gay/Lesbian ☐ Prefer not to say ☐ 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	☐ Arab/British Arab	☐ Asian/British Asian
	☐ Black/Black British	☐ Carribean	☐ Chinese
	☐ European	☐ Gypsy/Roma	☐ Indian
	☐ Mixed heritage	☐ Pakistani	☐ White British
	☐ White Irish	☐ White other	☐ Prefer not to say
	☐ Other, please specify: ____________		

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

Marital Status:			
	☐ Married/Civil Partnership	☐ Single	☐ Divorced
	☐ Separated	☐ Living together	☐ Widowed
	☐ 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?				

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REFERRAL REASONS (Please add any relevant information)

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

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