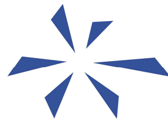

IMCA - Suffolk

East Suffolk Mind

ACE

Suffolk

Independent Mental Capacity Advocacy Service

Referral Form

We offer independent mental capacity advocacy to people who lack capacity and are facing important decisions about **serious medical treatment** or a **change of accommodation** and do not have family or friends who can speak on their behalf. We can also offer this service to people in **adult protection cases** and **care reviews**.

Referrers should read the "Joint Guidance on the Instruction of Independent Mental Capacity Advocates" before deciding whether to make a referral. For a copy of the Joint Guidance, please refer to www.imcasuffolk.org.uk or your internal policies, or to discuss the referral, please contact IMCA at IMCA Suffolk on 01449 771590.

The Functional Test of Capacity and a Decision Maker's name, need to be included before the referral can be activated. All sections of this form must be completed, and the form e mailed back to imca@optua.org.uk

Details of person requiring an IMCA:

Full Name of person referred:	
Date of Birth:	Sex: M / F
Address (current):	Address (home):
Telephone Number:	
Compass number ……………………. (Social Care)	NHS Number: …………………………

© IMCA Suffolk 2008 Updated July 2010

Ethnicity ………………………………….	Impairment………………………………

Decision: (please tick one only – *a separate referral form is required for each decision*)

Serious Medical Treatment	
Move to accommodation provided by a NHS Body	
Move to accommodation provided by a Local Authority	
Care Review	
Adult Protection Case	

Significant dates:

When does the decision need to be made by?	
Please give details of any impending meetings or deadlines	

Referrer's Details:

Name of Referrer:

Professional relationship to person being referred:

Contact Address:

Telephone Number:
Mobile Number:

Fax Number:
Email:

Significant Personnel Involved (*e.g. Doctors, Advocates, Friends, etc):*

Decision Maker's Name:
(*This section **must** be completed*)

© IMCA Suffolk 2008 Updated July 2010

Has the person <u>requested</u> the referral for an IMCA? Y / N

Is the person <u>aware</u> of the referral to the IMCA Service? Y / N

Is the person able to make their wishes known on this issue? Y / N

Is the person able to make some decisions without support? Y / N

Please outline the reasons why you feel the person requires an IMCA

How does the person prefer to communicate? *(tick all that apply)*

English	
Other language	
BSL	
Objects of reference/Makaton	
Gestures/vocalisations	
Facial expression i.e. eye referencing	
Other	
No obvious means of communication	

Is there any information the IMCA needs in order to keep the person and/or the IMCA safe (for example, health or behaviour issues)?

If the person has challenging behaviour, what are the triggers? How do they use it as a form of communication?

© IMCA Suffolk 2008 Updated July 2010

Particular time of day to meet client?
Please include any additional comments you feel are relevant:

If the client has family, but the family members are being excluded for the decision needing to be made, please state reasons why:

I confirm that for the above issue I am the Decision Maker on behalf of:

(Insert NHS Body or Local Authority)

for decisions regarding: (Insert Client Name)

I confirm that this person meets the criteria for the IMCA referral as set out in the *"Joint Guidance on the Instruction of IMCA's."*

Please complete & attach the *"The Functional Test of Capacity"* when submitting your referral. Thank you

This document can be emailed to us on imca@optua.org.uk but we must also receive a hard copy of the signed form in the post for our records.

Signed: ………………………………………………….. **Date**: …………………...

Please say how you heard about the IMCA Service: ……………………………………………………..……………………………...... …………………………………………………………………………..………....... …………………………………………………………………………..……….......

Please note that it is permissible for 3rd party referrers to send the referral form prior to the Decision Maker's confirmation being obtained. This will ensure that the client does not experience a delay in gaining the services of an IMCA.

© IMCA Suffolk 2008 Updated July 2010

Functional test of capacity

To be able to make a decision about whether an individual has the mental capacity to make a particular decision, it must first be established whether there is an impairment of, or disturbance in, the functioning of the person's mind or brain (it does not matter if this is permanent or temporary).

If there is, the second question to ask is whether the impairment or disturbance makes the person unable to make the particular decision.

The person will be unable to make the particular decision if, after all appropriate help and support to make the decision has been provided, he or she cannot:

- understand the information relevant to that decision
- retain that information
- use or weigh that information as part of the process of making the decision
- communicate their decision (whether by talking, using sign language or any other means).

Every effort should be made to find ways of communicating with someone before deciding that they lack the capacity to make a decision based solely on their inability to communicate. Very few people will lack capacity on this ground alone. Those who do might include people who are unconscious or in a coma or who suffer from a very rare neurological condition known as 'locked-in syndrome'. In many other cases such simple actions as blinking or squeezing a hand may be enough to communicate a decision. The input of professionals with specialised skills in verbal and non-verbal communication is likely to be needed when making decisions in this area.

Assessments must be made on the balance of probabilities - is it more likely than not that the person lacks capacity? Case records must demonstrate how the conclusion that someone lacks capacity to make a decision has been arrived at.

© IMCA Suffolk 2008 Updated July 2010

Functional test of capacity

Name of person you are referring……………………………………….

The person will be unable to make the particular decision if, after all appropriate help and support to make the decision has been provided, he or she cannot:

		YES	NO
1	Does the person you are referring understand the information relevant to that decision		
2	Does the person you are referring retain that information		
3	Does the person you are referring use or weigh that information as part of the process of making the decision		
4	Does the person you are referring communicate their decision (whether by talking, using sign language or any other means).		

Please indicate what help and support has been provided to help the person understand the decision.

Functional Test of Capacity Date Completed …………..

Signed:

Role:

Date:

Please return this form to:
IMCA Suffolk, Red Gables, Ipswich Road, Stowmarket, IP14 1BE
Fax to: 01449 770135 or email to: imca@optua.org.uk Email referrals need to be confirmed via fax/post as a signature is required. Thank you

© IMCA Suffolk 2008 Updated July 2010