Independent Mental Capacity Advocacy (IMCA) Service
Referral Form and guidance for the making of a best interests decision.

**Guidance**

1. This form must be completed in full by the person responsible for making the “best interests” decision.

2. Please consider statements a-d below. If you have answered yes to a-c, and yes to an element of statement d, a referral to the IMCA Service must be made.

3. **Guidance** for referrals regarding safeguarding adults and care reviews is on page 2.

4. Complete Section 1 of this form prior to making contact with the IMCA Service. This must be retained with client/patient notes.

5. Section 2 of this document acts as the referral form. Referrals for this service can be made initially by phone but must be followed immediately by a completed referral form. Receipt of a completed referral form will be the trigger for involvement of the IMCA Service.

6. Further detailed information regarding the process of appointing an IMCA can be found via the IMCA Pathways on both Durham County Council’s and Darlington Borough Council’s Intranet or on the Department of Health website: www.dh.gov.uk.

Independent Mental Capacity Advocates are provided to County Durham & Darlington by:

**Skills for People**  
Key House, Tankerville Place, Newcastle upon Tyne, NE2 3AT  
Telephone: 0191 281 7322  Fax: 0191 212 0300  Email: terri.clibery@skillsforpeople.org.uk

**NB:** The role of the IMCA is to support and represent the person who lacks capacity and to audit the way the “best interests” decision is being made. IMCAs do **not** make the decision on behalf of the person they are representing; the final decision will always be made by the decision maker.

---

**Eligibility for Service**
You are making this referral because:

a) A capacity assessment has been made under the arrangements of the Mental Capacity Act 2005 (Sections 3 MCA 2005/Code: Chapter 4) and as a result of this assessment the person is considered not to have the mental capacity to make the decision required and evidenced on Form SS546.

   Yes ☐  No ☐  Date assessment completed:______________________________

b) There is a “best interests” decision to be made (Section 4&5 MCA 2005/Code: Chapter 5)

   Yes ☐  No ☐  Date commenced:______________________________
c) To the best of your knowledge the person referred who lacks capacity does not have any friends or relatives to consult or it is impracticable to consult them (there is no one to speak for them), there is no nominated person, valid and applicable Advanced Decision, Court appointed Deputy and no EPA/LPA. *(This criteria does not apply to Safeguarding Adults cases)*

Yes ☐ No ☐

d) The decision to be made relates to: (please select)

- Serious medical treatment
  
  *(Guidance: Treatments regulated under Part 4 of the Mental Health Act 1983 are excluded from referral to the IMCA service)*

- NHS to arrange a hospital stay for 28 days or more

- NHS to arrange accommodation for 8 weeks or more

- The Local Authority proposes to provide or charge for residential accommodation for more than 8 weeks whilst acting under the National Assistance Act

**Guidance:** If you have answered “Yes” to options a) to c) and “Yes” to an element of d) please complete section 2 of this document *(The IMCA Referral Form)* and send it to the IMCA Service. If you have answered “No” or are unable to answer any of the questions seek advice before taking forward a referral to the IMCA Service.

---

**Care Review**

If your referral is related to care review and is consistent with the guidance on the pathway flowchart and you have answered “Yes” to a) to c) please continue to section 2 of this document.

Care Review: Yes ☐

**Safeguarding Adults**

If your referral is related to a safeguarding adults case and conforms to options a) and b) above a referral to the IMCA Service must be made - Continue to Section 2 of the document.

**OR**

If the person speaking for the person without capacity is considered not to be acting in the best interests of the person without capacity a referral should be made to general advocacy services and not the IMCA. If however the position is consistent with the exceptional criteria guidance on the pathway flowchart continue to Section 2 of the document.
Independent Mental Capacity Advocacy (IMCA) Service

Section 2

Referral Form

Persons Details
Full names of individual being referred to the Advocacy Service:
_____________________________________________________________________________
Address:______________________________________________________________________
_____________________________________________________________________________
Postcode: ___________________
Tel Number: __________________________ Date of Birth: ____________________________
Age: _________ Gender: Male □ Female □ (Please tick)
Current location of client: At above address □ Other (please specify below) □
Address:______________________________________________________________________
_____________________________________________________________________________
Postcode: ___________________

Referrers Details
Name of Referrer: _______________________________________________________________
Position Held: _________________________________________________________________
Organisation: (Please tick)
County Durham Primary Care Trust □ Darlington Primary Care Trust □
Durham County Council □ Darlington Borough Council □ Foundation Trust □
Mental Health Trust □
Contact Address: _______________________________________________________________
_____________________________________________________________________________
Postcode: ___________________
Tel: _________________ Fax:______________ Email Address: _________________________

Client Group (Please tick)
Mental Health □ Learning Disability □ Physical Disability □ Sensory Impairment □
Older People □ Older People Mental Health □ Substance Misuse □ Forensics □
C&YPS □

Reason for Referral (Please tick)
Serious Medical Condition □ Change of Residence □ Adult Safeguarding □
Care Review □
Assessment for capacity completed? Yes □ No □ Date: ___/___/_____ 

Provide a brief summary of the decision to be made:

Estimated date by which report from IMCA is required: ___/___/_____ (dd/mm/yyyy)

Date of next key meeting relating to decision: ___/___/_____ (dd/mm/yyyy)

Does the person have any specific language or communication needs? Please detail:

Who are the key people for the IMCA Service to contact e.g. professionals, carer, others.

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is there a risk to the advocate interviewing the person alone or any risk factors they should be aware of? (E.g. previous history of violent, aggressive or unpredictable behaviour)

Yes □ No □ Unable to assess □ If Yes, what is it?

In order to ensure that the service is inclusive, please indicate below the ethnicity of the person being referred to the service.

<table>
<thead>
<tr>
<th>White</th>
<th>Black or Black British</th>
<th>Caribbean</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White Irish</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other white background</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mixed</th>
<th>Asian or Asian British</th>
<th>Indian</th>
</tr>
</thead>
<tbody>
<tr>
<td>White and Black Caribbean</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White and Black African</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White and Asian</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Other Ethnic groups            |                         |           |
| Chinese                        |                         |           |
| Any other ethnic group         |                         |           |

Date of Referral: ___/___/_____ (dd/mm/yyyy)

Signature of Referrer: .................................................... Date: ___/___/_____ 

Please send completed form to: Key House, Tankerville Place, Newcastle, NE2 3AT or alternatively fax: (0191) 212 0300 or telephone: (0191) 281 7322.

NB: Telephone referrals must be confirmed in writing within 24 hours of the initial referral.

For office use only
Date request received by advocacy office: ___/___/_____ 

Date of first meeting: ___/___/_____ 

IMCA Referral Form Page 4 of 4 Version 4