Plymouth Advocacy

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Independent Mental Health (IMHA) and Informal Inpatient Referral

seAp provides the Plymouth Advocacy IMHA service.
This form can be used by professionals to refer both Qualifying IMHA Patients and Informal Inpatients.
Alternatively, referrals can be made by telephone on 0300 343 5719.
Patients may also refer themselves directly to the advocacy service.

If completing online, click once on relevant box to check. Write in text fields, where required.

Qualifying Patients : This includes detained patients (excluding those subject to sections 4, 5(2), 5(4), 135 and 136), even if they are on leave or conditionally discharged. This also includes patients on s.17A Community Treatment Orders, s.7 Guardianship and informal patients under 18 who are being considered for ECT (for full eligibility, see Chapter 6 of the Mental Health Act 1983, Code of Practice). Patients with capacity must either consent to the referral OR the Responsible Clinician, AMHP or Nearest Relative believe that the patient might benefit from IMHA support but are unable or unlikely, for whatever reason, to request this for themself. All patients who lack capacity to decide whether or not to obtain help from an IMHA must be referred to the service.

The Patient is a Qualifying Patient ☐

To which section(s) of the MHA is the patient subject (if known)?

Informal Inpatients : Although informal inpatients and those detained on short term/emergency sections do not have a legal right to an IMHA, seAp advocates may be able to provide advocacy on an informal basis, subject to availability.

The Patient is an Informal Inpatient ☐

Date Sent:

PATIENT INFORMATION

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Other	**Full Name:**
Date of Birth:	**Has patient consented to this referral?** ☐ Yes ☐ No
Gender: ☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M ☐ Prefers not to say ☐ Other (specify)	
Permanent Address: **Postcode:**	**Current Location:** **Postcode:**
Telephone No.	**Telephone No.**

Name of Responsible Clinician/Consultant Psychiatrist:

Date of Detention (if applicable):

Please give brief details of the situation requiring an advocate:

Is the patient subject to seclusion? ☐ Yes ☐ No

Plymouth Apr 2016

seAp advocacy Support Empower Advocate Promote

Plymouth Highbury Trust

RAD Royal Association for Deaf people

Are there any deadlines or important meeting dates?

Are there any risk factors of which the advocate should be aware?

Does the patient have capacity to request / instruct an advocate? ☐ Yes ☐ No

Permission to Share: Can an advocate be contacted in the event of discharge into Guardianship or Community Treatment Order? ☐ Yes ☐ No

Is this a self-referral? ☐ Yes ☐ No If No, please give Referrer details below

Referrer Name:

Job Title / Employer:

Tel No: **Email:**

PATIENT INFORMATION (check ONE box only in each section)

Ethnic Background

White
- ☐ British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Any other White background (specify)

Mixed Ethnic Groups
- ☐ White & Black Caribbean
- ☐ White & Black African
- ☐ White & Asian
- ☐ Any other Mixed ethnic background (specify)

Black / Black British
- ☐ African
- ☐ Caribbean
- ☐ Any other Black/African/Caribbean background (specify)

Asian / Asian British
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background (specify)

Other Ethnic Group
- ☐ Arab
- ☐ Any other ethnic group (specify)

- ☐ Ethnicity not known
- ☐ Prefers not to say

Sexual Orientation
☐ Lesbian ☐ Gay Man ☐ Heterosexual
☐ Bisexual ☐ Other (specify)
☐ Questioning ☐ Not known ☐ Prefers not to say

Marital or Civil Partnership Status
- ☐ Single
- ☐ Co-habiting
- ☐ Married
- ☐ In Civil Partnership
- ☐ Separated (but still legally married / in civil partnership)
- ☐ Divorced or Civil Partnership Dissolved
- ☐ Widowed
- ☐ Surviving partner of Civil Partnership
- ☐ Not known ☐ Prefers not to say

Religion or Belief
- ☐ Buddhist
- ☐ Christian (all denominations)
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ No Religion
- ☐ Other (specify)
- ☐ Not known ☐ Prefers not to say

Does the Patient consider themself to have a disability?
☐ Yes (give details below)
☐ No ☐ Not known
☐ Prefers not to say

Does the Patient have a Military connection?
☐ Yes, Serving ☐ Yes, Veteran
☐ Yes, Carer relationship ☐ No
☐ Not known ☐ Prefers not to say

Please e-mail the completed form to: Plymouth@seap.org.uk

or post to: P O Box 375, Hastings, TN34 9HU

or fax to: 01424 204 687

If referral confirmation not received within 2 working days, please contact Plymouth Advocacy on: **0300 343 5719**

All records are held in accordance with current Data Protection legislation.