

**HertsHelp Advocacy Referral Form**

**Independent Mental Health Advocacy (IMHA)**

|  |  |
| --- | --- |
| **Name:** |  |
| **Date of Birth:** |  | **Gender:** | Male | Female |
| **Permanent****Address:** |  |
|  |
|  |
| **Post Code:** |  |
| **Telephone No.** |  |

**Where is the person currently staying?**

|  |  |
| --- | --- |
| **Current Location: (Hospital, home etc)** |  |
|  |
|  |
| **Post Code:** |  |
| **Telephone No:** |  |

**Qualifying patients for IMHA – detained patients (please tick****)**

|  |  |
| --- | --- |
| Is the person detained under the Mental Health Act?**\*** |  |
| Is the person subject to Supervised Community Treatment (SCT) or conditional discharge? |  |
| Is the person subject to guardianship? |  |

**\*** excluding those subject to sections 4, 5(2), 5(4), 135 or 136

**Qualifying patients for IMHA – informal patients (please tick****)**

The right to IMHA support also applies to:

|  |  |
| --- | --- |
| Informal patients who are liable to be detained under the Act |  |
| Informal patients who are discussing the possibility of being givensection 57 treatment. (Treatment which requires consent and a second opinion) |  |
| People under 18 who are being considered for electro-convulsive therapy (ECT) |  |

**Please give brief details of the situation that requires IMHA involvement**

*Continue on separate sheet if necessary*

**Are there any deadlines or important meeting dates? (MHA Tribunals, Hospital managers reviews, CPA review)**

**Communication Needs**

**Referrer details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Is this a self-referral? (Please tick****)** | **Yes** |  | **No** |  |

|  |  |
| --- | --- |
| Name of referrer |  |
| Professional or family member |  |
| Contact Address |  |
|  |
|  |
| Telephone Number |  |
| Email address |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Has the client consented to the referral to theIMHA Service? | **Yes** |  | **No** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of referrer |  | Date |  |