Rethink IMCA service represents and supports individuals in Wiltshire excluding Swindon who meet all the following criteria:

The person referred has no appropriate family or friends to represent them and the referrer believes that they lack the capacity to make decisions concerning:

a. Serious medical treatment OR

b. Long term accommodation moves (more then 28 days in hospital/8 weeks in a care home) OR

c. Care reviews or

d. Safeguarding

|  |  |
| --- | --- |
| Client Information | |
| Full Name : | Date of Birth : |
| Gender : Male |
| Address at point of referral :  Postcode : | Home Address :  Postcode: |
| Tel no : | Home Tel no : |
| Contact Name at Referral Address: | Contact Name at Home address: |

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| Ethnic Origin ( Please indicate as appropriate ) |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| White British | White Irish | Black  Caribbean | White/ Asian | Bangladeshi | Indian | Chinese |
| Other white background | Black African | Other black background | White/Black  African | Other mixed background | Other Asian background | Other ethnic group |

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| --- | --- | --- | --- |
| **Nature of Illness or impairment ( please indicate one or more as appropriate )** | | | |
| Learning Disability | Mental illness | | Dementia |
| Serious Physical Illness | Acquired Brain Injury | | Unconscious State |
| Other : please give brief description : | | | |
| **Preferred communication method ( please indicate and give brief details as appropriate )** | | | |
| Pictures/symbols/makaton | English | | Another spoken language |
| British sign language | No obvious communication | | Gestures/vocalisations/facial expressions |
| Other – please specify | | | |
| **Who is the IMCA decision maker?**  The decision maker is the individual within either the local authority or the NHS body who has the responsibility for making the decision on issues of change of accommodation or serious medical treatment on behalf of the client who has been assessed as lacking capacity on either issue. A third party can make the referral if they have the permission of the decision maker to do so. | | | |
| REFERRER DETAILS | | DECISION MAKER DETAILS ( IF DIFFERENT ) | |
| Name : | | Name : | |
| Job title | | Job title | |
| Organisation | | Organisation | |
| Address  Postcode | | Address  Postcode | |
| Landline number: | | Landline number: | |
| Mobile Number : | | Mobile Number : | |
| Email Address : | | Email Address : | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Person to contact to arrange meeting the client : | | | |  | | | | |
| Has the client been formally assessed to lack capacity? | | | | Yes | | |  | |
| Name and Job title of assessor : | | | | | | | | |
| Date of assessment : | | | | | | | | |
| Decision to be made : | | | | | | | | |
| Serious medical treatment | Adult protection | | Change in  accommodation | | | | Care review | |
| Please provide details | | | | | | | | |
| Details of important deadline or meeting dates | | | | | | | | |
| Is there appropriate family and friends to consult with ? | | | | |  | | | No : |
| If there are family, friends why is a IMCA needed ? | | | | | | | | |
| Please provide names and contact details of anyone else who can help from true picture of the clients wishes and feelings. | | | | | | | | |
| Signature of the decision-make or authorised  Person : | | Print Name : | | | | Date : | | |