

IMCA REFERRAL FORM - AYLESBURY VALE ADVOCATES / AGE CONCERN BUCKINGHAMSHIRE

Please tick boxes as appropriate and use block capitals or if using email, double click on the box, then click on the ‘checked’ circle, then click ‘OK’

Date of referral : (dd/mm/yyyy)	Client ID. (for IMCA office use only)
Client’s first name:	Client’s family name:
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Client’s usual address:	Current address (if different):
Postcode:	Postcode:
Phone No:	Phone No:
Funding Authority:	Funding Authority:
Age <input type="checkbox"/> 16 - 17 <input type="checkbox"/> 18 - 30 <input type="checkbox"/> 31 – 45	<input type="checkbox"/> 46 – 65 <input type="checkbox"/> 66 – 79 <input type="checkbox"/> Not known <input type="checkbox"/> 80 and over

Ethnic Background			
White <input type="checkbox"/> British	<input type="checkbox"/> Irish	<input type="checkbox"/> Other White	
Mixed White <input type="checkbox"/> White & Black Caribbean	<input type="checkbox"/> White & Black African	<input type="checkbox"/> Other Mixed White (specify)	
	<input type="checkbox"/> White & Asian		
Asian or Asian British <input type="checkbox"/> Indian	<input type="checkbox"/> Bangladeshi		
	<input type="checkbox"/> Pakistani	<input type="checkbox"/> Other Asian (specify)	
Black or Black British <input type="checkbox"/> Black Caribbean	<input type="checkbox"/> Black African	<input type="checkbox"/> Other Black (specify)	
Chinese or other ethnic group <input type="checkbox"/> Chinese	<input type="checkbox"/> Other ethnic category (specify)		

Nature of client’s Impairment / disability	
<input type="checkbox"/> Unconsciousness	<input type="checkbox"/> Dementia
<input type="checkbox"/> Autism Spectrum Condition	<input type="checkbox"/> Learning Disability
<input type="checkbox"/> Mental Health problems	<input type="checkbox"/> Cognitive impairment
<input type="checkbox"/> Serious physical illness	<input type="checkbox"/> Combination
<input type="checkbox"/> Acquired brain damage	<input type="checkbox"/> Other (please state):

Where was the client at the time of referral? Specify name of hospital, care home etc.	
<input type="checkbox"/> Own home	<input type="checkbox"/> Uncertain
<input type="checkbox"/> Care / nursing home (name)	<input type="checkbox"/> Prison (name)
<input type="checkbox"/> Hospital (name)	<input type="checkbox"/> Other (please state):
<input type="checkbox"/> Supported living (name)	

Where is the referral from? (eg hospital discharge team, social work team, care home manager. Please identify team and location).

IMCA REFERRAL FORM - AYLESBURY VALE ADVOCATES / AGE CONCERN BUCKINGHAMSHIRE

Client's primary means of communication

- | | |
|---|--|
| <input type="checkbox"/> English | <input type="checkbox"/> Gestures / Facial expressions / vocalisations |
| <input type="checkbox"/> Other spoken language | <input type="checkbox"/> No obvious means of communication |
| <input type="checkbox"/> British Sign Language | <input type="checkbox"/> Other (please state) |
| <input type="checkbox"/> Words / pictures / Makaton | |

What is the decision to be made?

Serious medical treatment →

What is the proposed medical treatment?

- Cancer treatment
- Hip/leg operation
- DNAR
- Medical investigations
- Serious dental work
- ECT
- Major amputations (arm or leg)
- Treatment that may lead to loss of hearing or sight
- Major surgery (eg open heart or brain / neuro-surgery)
- ANH
- Termination of pregnancy
- Other (please specify)

Change in accommodation →

- | | |
|--|--|
| From: | To: |
| <input type="checkbox"/> Own home | <input type="checkbox"/> Own home |
| <input type="checkbox"/> Care/nursing home | <input type="checkbox"/> Care/nursing home |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Supported living | <input type="checkbox"/> Supported living |
| <input type="checkbox"/> Prison | <input type="checkbox"/> Other (please state): |
| <input type="checkbox"/> Other (please state): | <input type="checkbox"/> To be decided |

Adult Protection Care Review Other (please state):

Has the decision been made yet?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	When does the decision need to be made?	Date: (dd/mm/yyyy)
--	---------------------------------	--------------------------------	---	--------------------

Capacity test conducted by:	Decision-maker <input type="checkbox"/>	Other Professional <input type="checkbox"/>	Other person (please specify) <input type="checkbox"/>
------------------------------------	--	--	---

Decision-maker's recommended course of action	
Please list deadlines and meeting dates	



IMCA REFERRAL FORM - AYLESBURY VALE ADVOCATES / AGE CONCERN BUCKINGHAMSHIRE

Are there friends or family to consult?	Yes, but adult protection referral <input type="checkbox"/>	No <input type="checkbox"/>	Uncertain <input type="checkbox"/>	Yes, but deemed 'inappropriate to consult' <input type="checkbox"/>
--	--	--------------------------------	---------------------------------------	--

Describe any concerns about family/friend involvement e.g. not regular contact, conflict of interest	
List contact details of relevant people e.g. Care Manager, Key worker Day Centre etc.	

Consent for referral: By submitting this form, the decision-maker is confirming that they are referring and providing information in the person's best interests

Decision-maker's name	
Relationship to client <input type="checkbox"/> Consultant / Doctor <input type="checkbox"/> Social worker	<input type="checkbox"/> Other (please state)
Address	
Email	
Telephone number	
Mobile telephone number	
Employing Local Authority or NHS body	

Please return completed forms to :	
<p>Aylesbury Vale Advocates, Pembroke Court, 28 Cambridge street, Aylesbury HP20 1RS Telephone / Fax 01296 432313 Email: support@av-advocates.org.uk (Charity Registration 1063911)</p>	
OR	
<p>Age Concern Buckinghamshire, 145, Meadowcroft, Aylesbury Bucks HP19 9HH Telephone 01296 397035 Fax 01296 330783 Email: ageconcern@ageconcernbucks.org.uk (Charity Registration 204798)</p>	

IMCA TELEPHONE REFERRAL LINE – 01296 397035