

Vision Advocacy Service

Date form completed:	Date received by Vision Advocacy:
-----------------------------	--

Person who is referring the patient

Name:	Organisation:
Designation (Job title: e.g. AMHP, responsible clinician, nearest relative)	Contact number:
Address:	

The Patient

Name of patient:	Date of birth:	Gender: Male Female
Ward/Currently residing at OR home OR permanent address (if guardianship/conditionally discharged or CTO patient)	Contact number:	
	Is English their first language? Yes No	
	If not would the patient like an interpreter? Yes No	
	What language is preferred?	
Any special requirements:	Reasons for referral:	
Has the patient consented to this referral?	YES	NO
*A referral can still take place if the patient has been assessed to not have the capacity to make this decision		

Vision Advocacy Service

How does this patient qualify for IMHA?

Qualifying Reason	Please tick whichever applies
Detained under the MHA (even if they are currently on leave of absence from hospital) apart from those patients detained under sections 4, 5(2), 5(4), 135 or 136	
Conditionally discharged restricted patients	
Subject to Guardianship under the Act	
On Supervised Community Treatment (SCT)	
Being considered for a treatment to which section 57 applies (a section 57 treatment)	
Under 18 and being considered for electroconvulsive therapy or any other treatment to which section 58A applies (a section 58A treatment)	

Responsible person who gave verbal and written information about IMHA services to qualifying patients?

Name:
Contact details including phone number:
When was this duty undertaken?

Date and signature of referrer

Signature

Date

Completed referrals can be sent by post or faxed to:

MhIST
30 Chorley New Road
Bolton BL1 4AP

Fax: 01204 528 311
Tel: 01204 527 200

**We are unable to accept
referrals via email or telephone**