Mackay Advocacy Inc

Suite 5 City Court
78 Victoria Street
P.O. Box 174
Mackay Q 4740
Ph: 07 4957 8710
ABN 83 685 183 540

Acting and speaking on behalf of people with disability
...not instead of!

Email: admin@mackayadvocacy.com.au

REFERRAL TO MACKAY ADVOCACY INC

DATE:	Referred By: ❑ Self ❑ Third Party

ELIGIBILITY – *Please note that prospective clients must be between the ages of 0 – 65 yrs., have a permanent intellectual, psychiatric, cognitive, neurological, sensory or physical impairment, experiencing or be at risk of harm, neglect, abuse and/or exploitation.*

CLIENT DETAILS

Client Name:		
Address:		
City:	**State:**	**Postcode:**
DOB:	**Age:**	**Male ❑ Female ❑**
Phone:		
Email address:		

Disability *(as per Disability Services ACT 3.11)*

What is a Disability

❑ intellectual ❑ psychiatric ❑ cognitive ❑ neurological	❑ sensory ❑ physical impairment ***or*** ❑ a combination of impairments mentioned above
Diagnosis:	

Is the client at risk of harm, Neglect, Abuse or Exploitation? Yes ❑ No ❑

Is the client under 18yrs old? Yes ❑ No ❑
Parent/Guardian/Support Person Contact Name:
Phone Number: Home/Office: *MOB:*

Cultural Background:

Is an interpreter required? Yes❑ No ❑ *if yes what language:*

Is there a Public Guardian appointed? **Yes❑ No ❑**
if yes contact details for authority to act:
Name: *Phone Number:*

Is there a Public Trustee appointed?	**Yes❑ No ❑**
if yes contact details for authority to act:	
Name:	*Phone Number:*

THIRD PARTY DETAILS

Name/Organisation:	
Relationship to the person:	
Phone Number:	
Email Address:	
Does the person know and consent to you making this referral?	**Yes❑ No ❑**

REASON FOR REFERRAL

Office Use Only

❑ *Accepted for Intake / / by _____Signature _____*
❑ *Accepted for Intake but placed on waiting list until / /*
❑ *Referred onto _____*
❑ *Not eligible for advocacy*
❑ *Is there another available service? Yes ❑ No ❑*
❑ *Do not have capacity at this time due to high demand*
❑ *Registered as Unmet Need*