Mackay Advocacy Inc

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

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REFERRAL TO MACKAY ADVOCACY INC

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.*

IMPORTANT INFORAMTION *– Please note that Mackay Advocacy does NOT provide legal or financial advice.*

DATE:	Referred By: ❑ Self ❑ Third Party
Does this client require legal advice or representation? Yes❑ No ❑ **If no,** please continue with referral. **If yes,** please contact Mackay Regional Community Legal Centre PH: 4953 1211 OR Legal Aid Queensland PH: 4936 5600	
Does this client require advice on a tenancy situation? Yes❑ No ❑ **If no,** please continue with referral. If yes, please contact QStars Ph: 1300 744 263	

CLIENT DETAILS		
Client Name:		
Address:		
City:	**State:**	**Postcode:**
DOB:	**Age:**	**Male ❑ Female ❑**
Phone:		
Email address:		
THIRD PARTY DETAILS:		
Name / Organisation:		
Relationship to the Person:		
Phone Number:		
Email Address:		
Does the person know and consent to you making this referral?		
CRN Number:		

NDIS Number:

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:_____

What is the Disability *(as per Disability Services ACT 3.11)*

❑ intellectual
❑ psychiatric
❑ cognitive
❑ neurological
❑ sensory
❑ ABI
❑ Cerebral Palsy
❑ Asperger's
❑ Austism
❑ physical impairment
❑ a combination of impairments mentioned above
❑ Other **/** Please specify below
Details:_____

Diagnosis: _____

Mental Health

❑ Bi Polar
❑ Schizophrenia
❑ Substance abuse
❑ PTSD
❑ Psychosis
❑ Anxiety
❑ Depression
❑ Phobia
❑ OCD
❑ Other **/** Please specify below

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: _____

Are there any involuntary treatment orders? Yes ❑ No ❑
If Yes, Case Worker Details:
Name: _____Phone Number: _____

Are there any forensic Orders? Yes ❑ No ❑
If Yes, Case Worker Details:
Name: _____Phone Number: _____

Cultural Background

❑ Aboriginal
❑ South Sea Islander
❑ Torres Strait Islander
❑ Non- English Speaking
❑ N/A

Is an interpreter required? Yes❑ No ❑

if yes what language: __

Immediate Risk

❑ Victim ❑ Perpetrator
❑ Incarceration
❑ Court Appearance:
❑ QCAT
❑ Homelessness
❑ Removal of Children
❑ Abuse by family / service provider
❑ Loss of Service Prevision

❑ Civil
❑ Criminal
❑ Child Protection
❑ Family
❑ Mental Health Tribunal
❑ Mediation
❑ Hospital Admission:
❑ Acute Care
❑ Emergency Department
❑ General Admission
❑ Financial
❑ Tenancy
❑ Employment
❑ Assault
❑ Domestic Violence
❑ Other
Details:_____

Accommodation

❑ Independent Living
❑ Own Home
❑ Living with Family
❑ Department of Housing
❑ Group Home
❑ Short Term Accommodation
❑ Other
Details: _____

Do you need in home support?
❑ Yes
❑ No
Service Provider:_____

Communication

❑ Verbal
❑ Non-Verbal
❑ Communication Device
❑ Cannot read or has difficulty
❑ Cannot write of has difficulty
❑ Non-English

❑ Sign language
❑ Makaton
❑ Auslan
❑ Other
Details: _____
❑ Other **/** Please specify below
Details: _____

What Supports do you receive

❑ In-home support
❑ Community Access and Inclusion
❑ Parenting Support
❑ Counselling
❑ DVRS

❑ Lawyer
❑ Respite
❑ Financial Counselling
❑ Other **/** Please specify below
Details:_____

Transportation

❑ Private Car – Family ect.
❑ Friends Transport
❑ Bus
❑ Taxi

❑ HACC Services
❑ Community Visitor
❑ Other **/** Please specify below
Details:_____

Other Information

Do you hold a driver's license? Yes❑ No ❑
Do you live independently? Yes❑ No ❑
Do you have family involvement? Yes❑ No ❑
What family involvement?_____

_____

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