Mackay Advocacy Inc

22 Nelson Street
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Mackay Qld 4740
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Are you a person that identifies as First Nations, Culturally and Linguistically Diverse, or a young person under 18 years old? We suggest that you contact the *specialist cohort* that we will be best able to assist you.

First Nations people with disability - Aboriginal & Torres strait Islander Disability Network of Qld
PHONE: 1800 718 969 WEB: https://atsidnq.com.au/

People from culturally and linguistically diverse backgrounds - Amparo Advocacy Inc.
PHONE: (07) 3354 4900 Web: https://www.amparo.org.au/

Children and younger people with a disability (0-18years) - Queensland Advocacy Inc.
PHONE: 1800 718 969 Web: https://qai.org.au/

REFERRAL FORM TO MACKAY ADVOCACY

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

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

PERSONAL DETAILS OF PERSON BEING REFERRED		
Name:		
Address:		
City:	**State:**	**Postcode:**
DOB:	**Age:**	**❑ Male ❑ Female ❑ Other**
Phone:		
Email address:		

Cultural Background

❑ Aboriginal ❑ Torres Strait Islander ❑ South Sea Islander ❑ N/A

❑Non-English Speaking

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

Is the person under 18yrs old? ❑ Yes ❑ No

Parent/Guardian/Support Person Contact Name:_____

Phone Number: Home/Office: _____MOB: _____

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

❑ intellectual ❑ Asperger's
❑ psychiatric ❑ Austism
❑ cognitive ❑ physical impairment
❑ neurological ❑ Cerebral Palsy
❑ sensory ❑ ABI
❑ Other **/** Please specify_____

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

Immediate Risk

❑ Abuse by family/service provider ❑ Loss of Service Prevision ❑ Assault ❑ Domestic Violence
❑ Homelessness ❑ Incarceration ❑ Employment ❑ Hospital Admission ❑ Removal of Children
❑ Financial
❑ Court Appearance: ❑ QCAT ❑ Mental Health Tribunal ❑ Mediation ❑ Family
❑ Other, Details :_____

Communication

❑ Verbal ❑ Non-Verbal ❑ Communication Device ❑ Other, Details: _____
❑ Cannot read/has difficulty ❑ Cannot write/has difficulty
❑ Sign language; ❑ Auslan ❑ Makaton

Is there a Public Guardian/EPA/ Family Member appointed as a decision maker? ❑ 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:_____

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: _____

Accommodation

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

What Supports does the person receive?

❑ In-home support, provide by: _____

❑ Community Access and Inclusion, provide by: _____

❑ Respite, provided by: _____

❑ Parenting Support, provided by:_____

❑ Financial Counselling, provided by: _____

❑ Counselling, provided by: _____

❑ Other, Details:_____

Does the person have a regular Doctor? ❑ Yes ❑ No

if **yes** contact details for GP:

Doctor Name: _____Practice: _____

Phone Number:_____

NDIS Number:

CRN Number:

Other Information

Hold a driver's license? ❑ **Yes** ❑ **No**

Have family involvement? ❑ **Yes** ❑ **No**

Please provide details on what family involvement?_____

_____

_____

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 – Please be as detailed as possible as to what you would like advocacy for and what role / outcome you would like from your advocate.

Office Use Only

- ❑ Details entered
- ❑ Initial intake complted on / /
- ❑ Not eligible for advocacy
- ❑ No capacity at this time due to high demand
- ❑ Requires specialist skill not available in organisation
  - ❑ Referred onto another organisation _____
  - ❑ Provide general information _____