

**Referral Form**

**Please refer to Eligibility Criteria and complete Questions 1 to 6 before completing referral form. Ensure referral form is completed in full before sending to** **admin@mackayadvocacy.com.au**

ELIGIBILITY – Prospective clients being referred must have a permanent intellectual, psychiatric, cognitive, neurological, sensory, or physical impairment and be experiencing, or be at risk of harm, neglect, abuse and/or exploitation.

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| **Q1. Is the person being referred identify as First Nations?** ❑ No, go to Q2 ❑ Yes – Another option is to contact below cohort for assistance. **Address Book outline**Aboriginal & Torres strait Islander Disability Network of Qld PHONE: 1800 718 969 / 1800 818 338 WEB: <https://atsidnq.com.au/> EMAIL: info@atsidnq.com.au |
| **Q2. Is the person being referred come from a Culturally and Linguistically Diverse background?** ❑ No, go to Q3❑ Yes – Another option is to contact below cohort for assistance. Address Book outlineAmparo Advocacy Inc.PHONE: (07) 3354 4900 WEB: [https://www.amparo.org.au](https://www.amparo.org.au/) EMAIL: info@amparo.org.au |
| **Q3. Is the person you are referring under 18 years of age?** ❑ No, go to Q4.❑ Yes – Another option is to contact below cohort; **Address Book outline**Queensland Advocacy Inc. PHONE: 1300 130 582 WEB: <https://qai.org.au/> EMAIL: qai@qai.org.au |
| **Q4. Does the person you are referring require legal advice or representation?** ❑ No, go to Q5. ❑ Yes – please contact below Legal Services for assistance. **Address Book outline**Mackay Regional Community Legal Centre PHONE: (07) 4953 1211 EMAIL: admin@mrclc.com.au**Address Book outline**Legal Aid Queensland PHONE: (07) 4936 5600 WEB: www.legalaid.qld.gov.au *\*\*Mackay Advocacy are NOT lawyers, therefore cannot give legal advice or assist in legal matters.*  |
| **Q5. Does the person you are referring require advice / advocacy on a tenancy situation?** ❑ No, go to Q6❑ Yes – please contact below for assistance; **Address Book outline**QStars (Queensland Statewide Tenant Advice and Referral Service)PHONE: 1300 744 263 WEB: https://qstars.org.au/ |
| **Q6. Does that person you are referring need assistance with a DSP application?** ❑ No, please complete referral. ❑ Yes – please contact the persons DES (Disability Employment Service) provider for assistance. OR contact **Address Book outline**Basic Rights Qld PHONE: 1800 358 511 EMAIL: brb@brb.org.au*\*\*Mackay Advocacy DO NOT assist with DSP applications.* |

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| **DATE: Referred By:** ❑ Self ❑ Third Party |
| **Name of person being referred:**  |
| **Address:**  |
| **City:**  | **State:**  | **Postcode:**  |
| **DOB:**  | **Age:**  | **❑ Male ❑ Female ❑ Other**  |
| **Phone: Email:**  |
| Are there any risk / issues / barriers that our staff would need to be aware of prior to contact?**❑ No ❑ Yes ……………………………………………………………………………………………………..** |
| **Cultural Background** **❑** Aboriginal ❑ Torres Strait Islander ❑ South Sea Islander ❑ N/A ❑Non-English Speaking Is an interpreter required? **❑ No ❑ Yes,** if yes what language:**\_*\_\_\_\_\_\_\_\_\_\_\_\_\_*** |
| **Guardian Information**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 Provision **❑** 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 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? ❑ No ❑ Yes,** please complete contact details for GPDoctor 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** |

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| **RISK AND ALERTS - Security Questions to answered before home visit.** 1. Is there clear numbering on the house/unit? ❑ Yes ❑ No
2. Is there street parking? ❑ Yes ❑ No
3. Are there any animals in the house? ❑ Yes ❑ No Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Is there mobile phone coverage at your house? ❑ Yes ❑ No
5. Does anyone smoke at the property? ❑ Yes ❑ No
6. Are there any hazards that our Advocate would need to be aware of for their visit? ❑ Yes ❑ No

Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Are there any weapons or guns in the home? ❑ Yes ❑ No

Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **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.** |

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| **Office Use Only**❑ Details entered ❑ Initial intake complted on / / ❑ More Information Required ❑ Accepted for Service ❑ Refered to Another organisation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Provide general information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |