Referral Form

If this is an urgent matter, please call the Advocacy for Inclusion office on 02 6257 4005

Date:

Name of referring individual:

Referral organisation:

Contact number:

Contact email:

Do you have the Consumer's permission to contact us?

*NB: we will **not** accept any referrals made without the person's consent*

☐ The person identifies as having a disability
☐ The person lives in the ACT
☐ Is this NDIS related? NDIS Number
☐ Have you contacted ADACAS about this issue as well?
☐ Have you contacted a lawyer about this issue?

Details of person needing support:

Name:

Phone:

Email:

Address:

Date of Birth:

Legal guardian (if applicable):

Do you identify as Aboriginal or Torres Strait islander or from a CALD background?

Main language spoken at home?

Disabilities (if stated)

Details of issue:

What would you like our Advocate to do?

Other Agencies/Support involved: (E.G. case manager, everyman, Support people)

Has this issue happened before?

Upcoming Important dates / meetings:

Office use

Agree to accept as Consumer?

Y / N

Advocate assigned: ______________________________

Priority: 1 2 3 4 5

If No, reason: ______________________________

Referred to other agencies: ______________________________

Any further action required: ______________________________

Informed consumer & entered in IVO: Date: ____________ Staff: ____________