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:

Client details

☐ The person identifies as having a disability

☐ The person lives in the ACT

☐ I have the consent from the person or their legal guardian to make this referral

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

Name:

Phone:

Email:

Address:

Date of Birth:

Access requirements

Important contacts (i.e. guardians):

Other:

Advocacy topic:

i.e. Access to justice, complaints, accommodation, NDIS access or assistance

☐ Self-advocacy support

☐ NDIS Appeals

Details of advocacy issue:

What would you like the advocate to do?

Desired outcome:

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

Important dates / meetings or deadlines:

Office use

Agree to accept as Consumer?

Advocate assigned:

Priority: 1 2 3 4 5

If No, reason:

Referred to other agencies:

Any further action needed:

Informed consumer & entered in IVO:

Staff:

Date: