**PLEASE USE 1 FORM PER PERSON**

**ENSURE YOU ENTER CORRECT CONTACT DETAILS**

|  |  |
| --- | --- |
| **Date Of Referral:** |  |
| **Referred By:** | Self-Referred  External Party |

**SECTION A – DETAILS OF PERSON BEING REFERRED**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  | | |
| Street Address: |  | | |
| Contact Number: |  | | |
| Date of Birth: | Age: | Male  Female  Other | |
| Disability/Disabilities:  **PLEASE DO NOT**  **LIST YOUR MEDICAL OR HEALTH CONDITIONS** |  | | |
| Cultural Background |  | | |
| Current Living Situation | Own  Private Rental  Public Housing  Homeless | | |
| Is there a Public Guardian Appointed?  *If a Public Guardian is in place for service provision, we are unable to provide advocacy without their consent.* | | | Yes  No |
| Is there a Power of Attorney or Enduring Power of Attorney? | | | Yes  No |
| Is the Public Trust appointed for financial management? | | | Yes  No |

**SECTION B – DETAILS OF EXTERNAL PARTY MAKING REFERRAL**

|  |  |
| --- | --- |
| Your Name / Organisation’s name: |  |
| Your relationship with the person: |  |
| Your Contact Number: |  |
| Does the person know and understand and consent to you making this referral? | Yes  No |

**REFERRAL PROCESS**

Once your referral is received, you will be contacted for an Intake Assessment in relation to your Spectrum of Vulnerability (SoV) under the National Disability Advocacy Program and your particular advocacy issue.

All referrals are discussed at Review Meetings and prioritised based on their SoV.

If Independent Advocacy Townsville cannot assist you, we may refer you to an alternative service and/or organisation.

**SECTION C – ADVOCACY DETAILS**

**Please give a brief over view of why you or this person requires advocacy.**

***Signature of person being referred***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_