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 REFERRAL FORM

REFERRED BY: DATE:

ORGANISATION:

EMAIL: PHONE:

**Send to** **admin@grampiansadvocacy.org.au** \* **ALLOW** up to 5 business days for a response referral



**PLEASE READ this checklist for who can be referred – place a cross into the square box**

 **Person has a disability** which is attributable to an intellectual, psychiatric, cognitive, neurological,

 sensory or physical impairment or a combination of those impairments OR is a carer/family member

 of a person with a disability

 **Lives in GdA catchment area** – West Wimmera, Horsham. Hindmarsh, Yarriambiack, Northern Grampians,

 Ararat, Hepburn, Ballarat, Moorabool Shires, (see map page 2)

 **There is a particular issue/s that the person needs help with**

\*\* if you have ticked ALL THREE boxes, please send through your referral to Intake: admin@grampiansadvocacy.org.au√

Office Use only:

|  |  |
| --- | --- |
| CLIENT NAME**CLIENT NAME**DATE OF BIRTH |  GENDER: FEMALE MALE OTHER  |
| ADDRESSPHONE NUMBERS |   |
| EMAIL ADDRESSPREFERRED METHOD OF CONTACT  |  |
| ABORIGINAL OR TSILANGUAGE SPOKEN |   INTERPRETER NEEDED? |
| DISABILITY DIAGNOSIS |   |
| ISSUE/s |  |
| OUTCOME/s SOUGHT |  |
| SUPPORTING EVIDENCE(e.g.MEDICAL REPORTS)PLEASE LIST |  |
| SUPPORTS – FORMALSUPPORTS - INFORMAL |  |
| DSP PARTICIPANTDSP APPEAL  | DATE OF REJECTION |
| LENGTH OF TIME ATTENDING JOB SERVICE PROVIDER (program of support) |  |
| NDIS PARTICIPANT | DATE OF DECISION TO BE APPEALED |
| ROYAL COMMISSION RELATED(DETAILS) >>> |  |
| DECISION MAKING STATUS(GUARDIAN, POWER of ATTORNEY) |  |
| HAS PERSON GIVEN CONSENT TO BECONTACTED BY GdA? | YES NO |

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