**ADACAS REFERRAL FORM**

The A.C.T. Disability, Aged and Carer Advocacy Service (ADACAS), is an independent, not-for-profit, advocacy organisation helping people with disabilities, older people and their carers.

ADACAS provides free independent advocacy in the ACT.

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| **Referrer Information:** | | |
| Referred by: | | Date: |
| Organisation/relationship to client: | | |
| Phone Number: | Email: | |
| Has the individual consented to this referral? Yes  No | | |

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| **Personal Client Information:** | | |
| Title: Mr  Mrs  Dr  Ms  Other | | |
| Given Name: Surname: | | |
| Date of Birth: | | Over 65  Under 18 |
| Address: | | |
| Suburb: | Postcode: | |
| Contact Number: (m) (h) | | |
| Email Address: | | |
| Preferred method of contact: mobile  home  email | | |
| Do you need an interpreter? Yes  No  If Yes, what language: | | |
| Do you identify as Indigenous and/or Torres Strait Islander? Yes  No | | |

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| **Give a detailed description of the issue you are seeking advocacy for?** |
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| Do you identify as having any of the following? |
| Disability  Mental health condition  Over 65  Are a carer |
| Are you a National Disability Insurance Scheme participant? |
| Yes  No |
| Do you have formal supports that help you with decisions, such as a Guardian or Enduring Power of Attorney? |
| Yes  No |
| If yes, would you like them to be included in your advocacy? |
| Yes  No |
| Name of legal guardian/EPOA holder:  Phone number:  Email address: |
| **Other services involved in your life:** |
|  |

Thank you for your referral. Please email this referral to [intake@adacas.org.au](mailto:intake@adacas.org.au) or return it to our office.

One of our Intake Officers will contact you to discuss the issue you are seeking advocacy for.

Each week, all requests are reviewed at a meeting, where we assess if we can assist you, or if another service would be more appropriate.

All information you provide to ADACAS will remain private and confidential.