AGENCY REFERRAL FORM

SEDAS South East Disability Advocacy Service
71 Suttontown RD Mount Gambier SA 5290
☎ (08) 87236002 **Fax:** (08) 87258009

SEDAS
South East Disability
Advocacy Service

Date of Referral ....

Name: Mr/Mrs/Ms/Miss ....

Address ....

Town.................................. State..... Post code.................................

Male ☐ **Female** ☐ **Date of Birth: ....../......../......**

Phone number: (...) (.............................) Mobile: (...)

Natue of this persons disability : ....

Ethnic Origin: .... **Language spoken at home:** ....

Interpreter Required? Yes ☐ **No** ☐

Please confirm this client/ guardian has agreed to this referral Yes ☐ **No** ☐

Is this person under any form of guardianship? : Yes ☐ **No** ☐

If Yes please state who the main Guardian is: ....

Contact for the Guardian: ....

Please note all guardians must give consent for referral except those clients under office of the public trustee if in doubt please contact us prior to making a referral

Nature of the issue/s

....

....

....

....

....

Details of person making the referral

Self referral	☐
Family member	☐
Carer	☐
Agency	☐
Other	☐

Details of referee (if not a self referral)

Name ....

Relationship to client

....

How did you find out about SEDAS

....

Staff member signature ....

Any further information regarding this person

....

....

....

....

....

....

....

....

....

....

....