Referral Form
Counselling and Education for People with Disability

Specialising in working with people with disability, providing education and counselling in sexuality, respectful relationships, and sexual wellbeing.

All sections must be completed in full. Referral to our service is voluntary and based on the idea of consent.

1. Details of person being referred:	
First Name:	**Surname**:
Date of Birth:	**Phone**:
Gender:	**Pronouns:**
Address:	
Suburb:	**Post Code:**
Email Address:	
Country of Birth:	**Language spoken:**

Aboriginal: Yes No **Torres Strait Islander:** Yes No

Is there a Guardianship Order in place? Yes No Not known

Is the person's legal guardian the Department of Communities Child Protection and Family Support?
Yes No

If yes, the name of the Case Worker: ______________________________

NDIS Information: We are registered for Improved Daily Living (CB Daily Activity)

Does the person have an NDIS Plan? Yes No

NDIS Number: ______________________________

Start Date: ____________________ **End Date:** ____________________

How is the plan being managed?

NDIA-Managed

Self-Managed
Email address for invoices: ______________________________

Plan-Managed
Agency managing the plan:

© The Family Planning Association of WA (Inc.) February 2022 V10

2. Person making referral: Self	
Name:	
Address:	
Suburb:	Post Code:
Phone:	Mobile:
Email Address:	
Relationship to person being referred:	

How did you hear about our service? ____________________

3. Next of kin details:	
Name:	
Address:	
Suburb:	Post Code:
Phone:	Mobile:
Email Address:	
Relationship to person being referred:	

4. Emergency contact details:	
Name:	
Address:	
Suburb:	Post Code:
Phone:	Mobile:
Email Address:	
Relationship to person being referred:	

5. Which service location(s) can you attend?

Northbridge   Joondalup   Mandurah

Albany   Bunbury   Busselton

Video Conferencing*

*Video Conferencing appointments can be offered via Zoom or Microsoft Teams. You will require access to a computer, phone or tablet with a camera and microphone.

6. Please indicate the day(s) available to attend sessions:

Monday   Tuesday   Wednesday   Thursday   Friday

© The Family Planning Association of WA (Inc.) February 2022 V10

7. Details of person(s) responsible for contact, to arrange an appointment or the cancellation of appointments:	
Name:	
Address:	
Suburb:	Post Code:
Phone:	Mobile:
Email Address:	
Relationship to person being referred:	

An appointment reminder text will be sent to mobile number: ____________________

Please tick if you **do not** want reminder texts sent.

8. Type of disability:

Autism
Intellectual
Physical
Psychosocial
Neurological
Unsure
Other: ____________________

9. Reason for referral:

____

____

____

10. Please indicate which topics you would like to cover in the sessions:

Couples' counselling
Counselling and support for LGBTQI+
Family and Domestic Violence counselling
Sexual abuse counselling
Pregnancy choice counselling
Respectful relationships
Friendships
Reproductive health
Feelings
Inappropriate Sexual Behaviour
Safer sex practices
Contraception
Hygiene and self-care
Menstruation
Consent, sex and the Law
Cyber Safety – sexting and bullying
Self-Esteem
Sexuality education
Public and private concepts
Masturbation
Protective education
Building resilience
Assertive communication
Puberty

11. Additional Information

Is any of the following relevant to the person being referred?

Behaviours of concern: Yes No

Brief details:

The Positive Behaviour Support Plan **MUST** be included. (Describe what you do to manage incidents).

Involvement in the Justice System: Yes No

Brief details:

Mental health issues: Yes No

Brief details:

Any current suicidal risk: Yes No

Brief details:

Please attach a current safety plan or risk management plan.

Any drug and/or alcohol issues: Yes No

Brief details:

Is the person at risk of a fall? Yes No

A history of falls

Is using medications that increase their risk of falls

Experiences of unexplained dizziness, light-headedness or 'blackouts'

Has limited mobility

Epilepsy

Other medical condition

Brief details:

Does the person require mobility equipment? Yes No
If yes, type of equipment: ______________________________

Does the person require mobility assistance to transfer? Yes No
If yes, please ensure the required amount of support people attend appointments.

The above will not discount people from receiving a service, but the information provided enables us to allocate the individual more appropriately.

Consent Form

It is important that the person being referred:

- Is aware of the reasons for referral
- Is willing to attend and participate
- Signs the consent form

Please ensure the consent form is signed by the person being referred OR the parent/legal guardian if the person is under 18 years.

I ______________________________(participant's name)

consent to attend SHQ disability counselling.

Signature of person being referred: ______________________________

Name of legal guardian (if applicable): ______________________________

Signature of legal guardian: ______________________________

Date: ____________________

For persons under the age of 18 years, it is a requirement that the parent(s) or a legal guardian consent to the child accessing the service and must attend the initial appointment with the child.

We are a registered NDIS Provider.

Please return the Referral Form to:

Email: support@shq.org.au
Post: SHQ Disability Team, 70 Roe Street, Northbridge WA 6003

© The Family Planning Association of WA (Inc.) February 2022 V10