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:

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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

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