

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 a 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:	

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	Video Conferencing*	Busselton

*Video Conferencing appointments can be offered via 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
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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 a parent 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