

Date of referral The participant/participant's
legal guardian has provided
consent for this referral? Yes No**Participant details**

Family name

Given names

Preferred name

Date of birth

Email

Phone number

SMS reminders

 Yes No

Street address

Suburb/
State:

Postcode:

Postal address

Suburb/
State:

Postcode:

School address (if applicable)

Suburb/
State:

Postcode:

Medicare Card Number

Individual reference

Gender

 Male Female Other

ATSI details

 Aboriginal Torres Strait
Islander Both NeitherLanguages
spoken

Ethnicity

Diagnoses
(if applicable)How did you
hear about us? NDIA Public Health Service Radio Other Provider Word of Mouth Other: _____

Allied Health Service (please tick)

- | | | |
|--|---|--|
| <input type="checkbox"/> Exercise Physiology | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Physiotherapy |
| <input type="checkbox"/> Psychology | <input type="checkbox"/> Social Work | <input type="checkbox"/> Speech Pathology |
| <input type="checkbox"/> Allied Health Assistant | <input type="checkbox"/> Behaviour Support | <input type="checkbox"/> Not sure (describe on page 3) |

Other

- | | |
|---|--|
| <input type="checkbox"/> Support Coordination | <input type="checkbox"/> Plan Management |
|---|--|

Legal guardian details

Name	<input type="text"/>		
Relationship	<input type="text"/>		
Contact number	<input type="text"/>	Mobile	<input type="text"/>
Email	<input type="text"/>		

Other contact details (i.e. referrer or carer)

Agency Name	<input type="text"/>		
Contact person	<input type="text"/>		
Role	<input type="text"/>		
Contact number	<input type="text"/>	Mobile	<input type="text"/>
Email	<input type="text"/>		

Support coordinator details (if different from above)

Agency Name	<input type="text"/>		
Contact person	<input type="text"/>		
Contact number	<input type="text"/>	Mobile	<input type="text"/>
Email	<input type="text"/>		

Reason for referral:**Previous intervention:**

Funding details:**NDIS**

NDIS Number

Plan start date

Plan end date

 Agency Managed Self-Managed NDIS Plan-Managed

NDIS Plan Manager

NDIS Plan Manager Email

Private **Parent/Carer/Individual
(with or without Medicare rebates)**If you have a referral from a GP, please send a copy
along with this referral form. **3rd Party Agency or Insurance**

Claim Number

NDIS fund allocation:If you have a set budget
you'd like to allocate to
Patches, please detail here:

Risk assessment:

- | | | | | | |
|-----|---|--------------------------|-----|--------------------------|----|
| 1. | Does the participant have current forensic issues or legal matters? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 2. | Does the participant have a history of self-harm or suicidal behaviour? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 3. | Does the participant have a history of violent behaviour? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 4. | Does the participant have a history of sex offences? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 5. | Does the participant experience violence in the home? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 6. | Are there safety concerns with the participants accommodation? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 7. | Are there concerns regarding the participant having their basic needs met (e.g. food security)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 8. | Are there concerns regarding the participants financial situation? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 9. | Does the participant have a previous or current psychiatric diagnosis? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 10. | Are there any other mental health or behavioural issues (other than discussed above) that might impact on the participant's ability to engage with therapy? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 11. | Are there safety hazards for therapists visiting the family home? e.g. dogs, unsafe behaviour? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 12. | Is the participant confined in a room or a physical space at any hour of the day or night? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 13. | Is the participant prescribed medication for the purpose of influencing their behaviour? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 14. | Are there any devices to prevent, restrict, or subdue the participant's body? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 15. | Is physical force ever used to prevent, restrict, or subdue the movement of the participant's body? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 16. | Is the participant restricted to accessing any parts of their environment, including all rooms in the house they live in, outside, items, or activities? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

Please describe any above responses as required:

Please send completed referral form and NDIS Plan (if applicable) to therapy@patches.com.au