



REFERRAL PROCEDURE
for the
PEOPLE 1st PROGRAMME (P.I.P.)

'Supporting People living with Disability in relationships, protective education and sexuality'

**People 1st Programme is a project of the Family Planning Association of WA (Inc)
Trading as SHQ**

People 1st Programme is registered for NDIS / WANDIS

Referral to the **People 1st Programme** is voluntary and based upon the idea of informed consent.

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 on Page 6

**All Sections MUST be completed
IN FULL**

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

Please return the Referral Form and Consent Form to

**Administration
People 1st Programme
PO Box 141
Northbridge WA 6865
Telephone: (08) 9227 6414
e-mail: info@pip.org.au**

People 1st Programme
REFERRAL FORM



1. **Details of person being referred:**

Name: _____

D.O.B: _____ Gender: _____

Address: _____

Post Code: _____

Phone Number: _____ Mobile Number: _____

Country of Birth: _____ Language spoken: _____

Aboriginal: Yes No Torres Strait Islander: Yes No

Does the client have a Guardianship order in place?

Yes No Not known

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

If so the name of the Case Worker: _____

2. **Details of Person(s) responsible for contact to arrange an appointment or the cancellation of appointments:**

Where possible a reminder of the appointment will be sent.

Name: _____

Address: _____

Post Code: _____

Phone Number: _____ Mobile Number: _____

Email address: _____

Relationship to client: _____

3. Details of Next of Kin:

Who do we contact in case of an emergency?

Name: _____

Address: _____

Post Code: _____

Phone Number: _____

Mobile Number: _____

Email address: _____

Relationship to client: _____

4. Details of Person Referring:

Name: _____

Address: _____

Post Code: _____

Phone Number: _____

Mobile Number: _____

Email address: _____

Relationship to client: _____

5. Which Service Location is most convenient?:

- | | | | | |
|-----------------------------------|---|------------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Perth | <input type="checkbox"/> Albany | <input type="checkbox"/> Bunbury | <input type="checkbox"/> Busselton | <input type="checkbox"/> Manjimup |
| Mon – Fri | Thurs & Fri | Wed & Thurs | Thurs & Fri | Wed |
| <input type="checkbox"/> Mandurah | <input type="checkbox"/> Video Conferencing | <input type="checkbox"/> Joondalup | | |
| Fri | Mon – Fri | Mon | | |

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

- Monday Tuesday Wednesday Thursday Friday

7. How did you hear about the People 1st Programme? _____

Client Information:

8. Type of Disability:

9. Reason for Referral:

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

- | | |
|--|--|
| <input type="checkbox"/> Couples' counselling | <input type="checkbox"/> Hygiene |
| <input type="checkbox"/> Domestic and Family Violence counselling support | <input type="checkbox"/> Menstruation |
| <input type="checkbox"/> Pregnancy Choice counselling | <input type="checkbox"/> Masturbation |
| <input type="checkbox"/> Gender and Sexual Diversity counselling | <input type="checkbox"/> Inappropriate Sexual Behaviour |
| <input type="checkbox"/> Sexual Orientation counselling | <input type="checkbox"/> Cyber Safety – sexting and bullying |
| <input type="checkbox"/> Sexual Abuse counselling | <input type="checkbox"/> Friendships |
| <input type="checkbox"/> Feelings; dealing with feelings and recognising feelings in others. | <input type="checkbox"/> Respectful Relationships |
| <input type="checkbox"/> Building Resilience | <input type="checkbox"/> Sex and the Law in WA & Consent |
| <input type="checkbox"/> Promotion of positive Self-esteem | <input type="checkbox"/> Sexuality Education |
| <input type="checkbox"/> Public and Private Concepts | <input type="checkbox"/> Safer Sex Practices |
| <input type="checkbox"/> Protective Education | <input type="checkbox"/> Contraception |
| <input type="checkbox"/> Assertive Communication | <input type="checkbox"/> Men's Reproductive Health |
| <input type="checkbox"/> Puberty | <input type="checkbox"/> Women's Reproductive Health |

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: _____

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

CONSENT FORM

***PLEASE ENSURE THE CONSENT FORM IS SIGNED BY THE PERSON BEING REFERRED**

OR

THE PARENT / GUARDIAN IF THE CLIENT IS UNDER 18

I _____ (Client's Name)

Consent to attend the People 1st Programme service.

*Signature of Person being referred _____

*Signature of legally appointed guardian: _____

Date: _____