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?:

☐ Perth	☐ Albany	☐ Bunbury	☐ Busselton
Mon – Fri	Thurs & Fri	Wed & Thurs	Thurs & Fri

☐ Video Conferencing

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:

☐Couples' counselling

☐Domestic and Family Violence counselling support

☐Pregnancy Choice counselling

☐Gender and Sexual Diversity counselling

☐Sexual Orientation counselling

☐Sexual Abuse counselling

☐Feelings; dealing with feelings and recognising feelings in others.

☐ Building Resilience

☐ Promotion of positive Self-esteem

☐Public and Private Concepts

☐Protective Education

☐Assertive Communication

☐Puberty

☐Hygiene

☐Menstruation

☐Masturbation

☐Inappropriate Sexual Behaviour

☐Cyber Safety – sexting and bullying

☐Friendships

☐Respectful Relationships

☐Sex and the Law in WA & Consent

☐Sexuality Education

☐Safer Sex Practices

☐Contraception

☐Men's Reproductive Health

☐Women's Reproductive Health

Additional information:

Does the person being referred have any of the following?

Behaviours of Concern: ☐Yes ☐No

Brief details: _____

_____

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

Is there any involvement in the Justice System: ☐Yes ☐No

Brief details: _____

_____

Mental Health Issues: ☐Yes ☐No

Brief details: _____

_____

Any current suicidal thoughts: ☐Yes ☐No

Brief details: _____

_____

A safety plan must be included.

Any current drug & / 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: _____

_____

_____

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: _____