



**REFERRAL PROCEDURE**  
for the  
**PEOPLE 1st PROGRAMME (PIP)**

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

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

**People 1<sup>st</sup> Programme is registered for NDIS**

Referral to the ***People 1<sup>st</sup> 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 to:**

**Email:** [info@pip.org.au](mailto:info@pip.org.au)

or

**Post:** People 1<sup>st</sup> Programme, 70 Roe Street, Northbridge WA 6003

# People 1<sup>st</sup> Programme (PIP) Referral Form



## 1. Details of person being referred:

Name: \_\_\_\_\_

D.O.B: \_\_\_\_\_

Gender: \_\_\_\_\_ Pronouns: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email Address: \_\_\_\_\_

Country of Birth: \_\_\_\_\_ Language spoken: \_\_\_\_\_

Aboriginal:  Yes  No Torres Strait Islander:  Yes  No

Does the person have 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:

Does the participant have an NDIS Plan?  Yes  No

NDIS Number: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

#### How is the Plan being managed?

**NDIA-Managed**  
Do you give PIP permission to complete a Service Booking for 31 hours?  Yes  No

**Self-Managed**  
Email address for invoices: \_\_\_\_\_

**Plan-Managed**  
Agency managing the plan: \_\_\_\_\_

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

**Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Suburb:** \_\_\_\_\_ **Post Code:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_ **Mobile:** \_\_\_\_\_  
**Email Address:** \_\_\_\_\_  
**Relationship to Participant:** \_\_\_\_\_

An appointment reminder text will be sent to **mobile number:** \_\_\_\_\_  
Please tick  if you **do not** want a reminder text sent.

**3. Details of next of kin:**

Same as above

**Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Suburb:** \_\_\_\_\_ **Post Code:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_ **Mobile:** \_\_\_\_\_  
**Email Address:** \_\_\_\_\_  
**Relationship to Participant:** \_\_\_\_\_

**4. Details of person referring:**

Same as above

**Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Suburb:** \_\_\_\_\_ **Post Code:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_ **Mobile:** \_\_\_\_\_  
**Email Address:** \_\_\_\_\_  
**Relationship to Participant:** \_\_\_\_\_

**5. Which service location is most convenient?**

- Northbridge                       Joondalup                       Mandurah\*  
 Albany                                   Bunbury                               Busselton  
 Video Conferencing

\*Mandurah is an outreach location. NDIS participants will incur travel costs as per NDIS policy.

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

- Monday       Tuesday       Wednesday       Thursday       Friday

**7. How did you hear about People 1<sup>st</sup> Programme?** \_\_\_\_\_

**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         |

**11. 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).

**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 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 person is under 18 years.**

I \_\_\_\_\_ (participant's name)  
consent to attend the People 1<sup>st</sup> Programme.

\*Signature of person being referred: \_\_\_\_\_

\*Signature of legally appointment guardian: \_\_\_\_\_

Date: \_\_\_\_\_