Referral Form

Referral date:

Referrals with incomplete and/or insufficient information will not be accepted.

SECTION A - Who Is Making This Referral?

Full Name:

Agency: Position/Title:

Phone: Email:

SECTION B - About the Person Receiving Services

First Name:

Last Name:

Chosen/Preferred Name:

Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Prefer not to say
☐ Not listed, please provide details

Birth Sex: *(sex assigned at birth)* ☐ Female ☐ Male ☐ Non-binary ☐ Prefer not to say
☐ Not listed, please provide details

Current Gender Identity: ☐ Female ☐ Male ☐ Non-binary ☐ Prefer not to say
☐ Not listed, please provide details

Date of Birth:

Address Type: ☐ Supported Living (SIL) ☐ Group Home ☐ Out of Home Care ☐ Private
☐ Not listed, please provide details

Address: Street

Suburb State Postcode

Alternate Address Type: ☐ Supported Living (SIL) ☐ Group Home ☐ Out of Home Care ☐ Private
☐ Not listed, please provide details

Alternate Address: Street

Suburb State Postcode

Contact Information: *(Client/Legal Guardian)* Contact information belongs to

Preferred contact method: ☐ Email ☐ Phone ☐ SMS ☐ Post

Email:

Telephone: Mobile Work

CULTURAL INFORMATION

Does the client identify as?

☐ Aboriginal ☐ Both Aboriginal & Torres Strait Islander

☐ Torres Strait Islander ☐ Neither Aboriginal & Torres Strait Islander

Aboriginal Language:

Aboriginal Community/Country:

Does the client come from a Culturally and Linguistically Diverse background?

☐ No ☐ Yes, please describe:

Primary Language:

Is an interpreter required?

☐ No ☐ Yes, provide details

COMMUNICATION & MOBILITY NEEDS - *Please do not leave this blank*

Please describe how the client communicates: (e.g. verbal, non-verbal, communication systems, Key Word Sign, etc)

Vision and Hearing Status:

☐ Unknown ☐ No concerns ☐ Hearing impaired, provide details:

☐ Vision impaired, provide details:

Assistive Technology Notes: *(e.g. what system? how is it accessed?)*

Mobility Needs:

MEDICAL INFORMATION - *Please do not leave this blank*

Medical Conditions:

Medications:

Diagnosis: *(including mental health conditions)*

Disability Type:

SECTION C - Funding Details Please complete at least one relevant section

NDIS

Client has NDIS PACE Plan? ☐ Yes ☐ No

NDIS Number:

Plan Start Date:

Plan End Date:

Payment Pathway:

- ☐ NDIA Managed
- ☐ Plan Managed
- ☐ Self Managed
- ☐ Multiple, provide details

NDIS Plan Manager / Self Managed Details
(who is responsible for payment?)

Name:

Phone:

Email:

NDIS Fund Allocation

Please detail the NDIS budget (incl. item numbers) to be allocated to SAL Consulting:

Mental Health Care Plan

Please send GP referral letter with this referral from

Medicare Number:

Mental Health Care Plan Date Date:

Plan End Date:

GP Name:

GP Provider Number:

Private / Other Contracts

Contract Manager/Contact Person Details:

Name:

Phone:

Email:

Invoicing Details (who is responsible for payments?):

Name:

Phone:

Email:

SECTION D - Requested Services & Supports

What services are you seeking?

Please refer to our website for a full list of the services and supports we provide. Some services may be unavailable in your state/territory. Please contact us on 1300 851 795 or info@salconsulting.com.au to find out.

Clinical Services

- ☐ Behaviour Assessment
- ☐ Behaviour Support Plan
- ☐ Service Model Assessment
- ☐ NMT Behaviour Assessment
- ☐ NMT Behaviour Support Plan
- ☐ NMT Implementation Support
- ☐ Risk Assessment
- ☐ Flexible Clinical Support

Psychological Services

- ☐ Psychological Assessment - please specify:
  - ☐ Cognitive
  - ☐ Functional
  - ☐ Cognitive & Functional
  - ☐ Neuropsych
  - ☐ Mental Health
  - ☐ FAS-D
  - ☐ Autism Spectrum Disorders
- ☐ Forensic Risk Assessment
- ☐ Parenting Capacity Assessment (OOHC)
- ☐ Decision Making Assessment

Therapy

- ☐ Psychological Therapy (counselling)
- ☐ Play Therapy
- ☐ Group Therapy

Occupational Therapy

- ☐ Sensory Assessment
- ☐ Formal Functional Assessment
- ☐ OT SIL/SDA/Home Living Assessment
- ☐ OT Therapy Sessions

Speech Pathology

- ☐ Communication Assessment
- ☐ Communication Support Plan
- ☐ Mealtime Management Plan
- ☐ Speech Therapy Sessions

Cultural Consultancy/Social & Emotional Wellbeing (SEWB)

- ☐ SEWB Informed Product/Service
- ☐ Flexible Cultural Consultancy Support

☐ **Not listed, please provide details:**

What are the current concerns? *Please do not leave this question blank*

What are you hoping to achieve with the support? *Please do not leave this question blank*

SECTION E - Background & Risk Information

Referrals with incomplete and/or insufficient information will not be accepted.

What are the behaviours of concern? (e.g. absconding, verbal aggression etc)

How are others preventing or responding to these behaviours? (e.g. locked doors etc)

Please describe any Alcohol & Other Drugs history, include current behaviours:

Please describe any forensic and/or offending history, include current behaviours:

Which implementing providers are involved? (e.g. SIL Accommodation, community access, day program etc)

Does the person have a current Behaviour Support Plan (BSP)? ☐ Yes ☐ No ☐ Unsure

BSP Expiry Date:

Please provide a copy of any previous and/or current Behaviour Support Plan(s) when submitting this referral.

Are there any Regulated Restrictive Practices (RRP) being implemented? ☐ Yes ☐ No ☐ Unsure

Are these RRP authorised? ☐ Yes ☐ No ☐ Unsure

If **Yes**, RRP Authorisation Expiry Date:

If **No**, date of first notification:

Please describe any known risks associated with the behaviour of concern
(e.g. to the person, others, property, health etc)

Client Visits

Please describe any known risks at the property our service is being provided:
(e.g. unrestrained animals, hoarding, squalor, rural/remote location, firearms etc.)

Please describe the impact other occupants or visitors at the premises may have on the visit:
(e.g. violence, aggression, smoking, drinking, drug use etc.)

Please describe any other factors that may impact the safety of the SAL Consulting clinician providing services:
(e.g. violence, aggression etc.)

SECTION F - Initial Contact

Referrals with incomplete and/or insufficient information will not be accepted.

Initial Contact - Who does the SAL Consulting clinician contact to initiate services?

Full Name: Relationship to Client:

Phone: Email:

SECTION G - Who Provides Consent for Services?

The consenting person is aware of this referral: ☐ Yes

Full Name: Relationship to Client:

Phone: Email:

The following people have been notified of this referral:

☐ Client ☐ Legal Guardian ☐ Regulatory Body (e.g. Quality and Safeguards Commission)

☐ Other Significant Person