REFFERAL FORM

CLIENT INFORMATION		
Client's full name:		
Date of Birth:	Age:	Sex: ☐ M ☐ F
Street address:		
Postal address:		
Mobile:	Home phone:	
Email:	Diagnosis:	
Name of primary carer/s (if applicable): Relationship to client: Emergency Contact Name Contact Phone Relationship Are there any court related orders? Y / N *If yes, please provide details or contact us separately with details relevant to sharing information or service provision.*		
School or other daytime location (if applicable):		
Address:		
Contact phone number:		
Email address:		

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Referral source (if relevant):
Previous therapy services provided by (optional):?

COUNSELLING & THERAPY SERVICES

Please list locations where you would like therapy to occur:

☐ Home address detailed above

☐ Workplace

☐ Online/Telehealth

If therapy services are being provided at home, please detail below any issues that your therapist needs to be aware of:

☐ Pets ☐ Smokers ☐ Specific parking requirements / restrictions:

☐ Other safety concerns or health concerns allergies relevant information:

Main Concerns / Goals for Counselling or Sensorimotor Art Therapy are:

INVOICE AND PAYMENT INFORMATION		
☐ **NDIS Participant**	☐ Self-managed	☐ Plan managed
NDIS Number		
Start and end date of current plan		
If plan managed: Name of Plan Manager: Contact details of Plan Manager: Mobile Email		
☐ **Private client**-payable on day of service via bank transfer or cash		
Other invoice or payment information:		
Client/Guardian signature: Date:		

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