Whole Hearts and Minds Services

New Referral

Person completing form: _____ Date: _____

PART A – PARTICIPANT INFORMATION

NDIS Participant Number: _____ DOB: _____
Preferred Pronouns (e.g. He/him, They/Their, She/Her): _____
First / Given Name(s): _____ Last / Family Name: _____
Phone: _____ Email: _____
Address: _____
_____

PART B – PARENT / CARER / NOMINEE INFORMATION

Relationship to client: _____
Preferred Pronouns (e.g. He/him, They/Their, She/Her): _____
First / Given Name(s): _____ Last / Family Name: _____
Phone: _____ Email: _____
Who should we contact to arrange appointments, etc? _____

PART C - PLANNER / COORDINATOR / OTHER (Contact person)

Preferred Pronouns (e.g. He/him, They/Their, She/Her): _____
First / Given Name(s): _____ Last / Family Name: _____
Phone: _____ Email: _____
Organisation: _____

PART D – NDIS PARTICIPANTS

- ☐ Self-Managed Funding
- ☐ Funding Managed by the NDIA
- ☐ Plan Management Provider (provide details below of your plan manager)

Name: _____
Organisation: _____
Phone: _____ Email: _____

PART E – DETAILS OF REFERRAL

Service requested: _____
Where do you want therapy to take place? _____
If requesting art therapy – what art medium, if any, do you have experience with?
_____
Reason/s for requesting therapy (e.g. NDIS goals, mental health management, relaxation, etc)
_____

PART F – DISABILITY

Diagnosis: _____

- ☐ Sensory. Details: _____
- ☐ Physical. Details: _____
- ☐ Cognitive / Acquired Brain Injury. Details: _____
- ☐ Mental Health. Details _____

**********Please return to admin@whamservices.com.au at your earliest convenience**********