**Referral Form – Counselling**

**Details of person being referred:**

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| --- | --- |
| Name: | DOB: |
| Address: | |
| Email: | Phone: |

**Details of person making the referral:**

|  |  |
| --- | --- |
| Name: | Relationship to person being referred: |
| Phone: | Email: |
| Has the person being referred consented to the referral: Yes  No | |
| Do you require an update of the referral status: Yes  No | |

**Is the person being referred an NDIS Participant?**

|  |  |
| --- | --- |
| NDIS Participant Number: | Plan end date: |
| Self Managed  Planner Managed  Plan Manager­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please note, we are unable to claim through Agency Managed funds | |
| Relevant NDIS Goals: | |

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| **Please provide a summary of any diagnosis relative to counselling:** |

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| **Please provide a brief description of any issues, concerns or goals relating to this referral:** |

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| **Other information:** |

Thank you for your time in completing this referral. We endeavour to respond to all queries and referrals within 2 business days.