



REFERRAL PROCEDURE
for the
PEOPLE 1st PROGRAMME (P.I.P.)
**'Supporting People with an Intellectual Disability in human relationships, protective
education and sexuality'**

Referral to the **People 1st 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
and
- Pay the required fee

Fees:

All persons wishing to obtain services delivered by the **People 1st Programme** are required to pay

\$50.00 for the Service.

The fee is paid at the initial appointment and gives you up to 7 sessions.

The Educator, and the person referred will agree what education is required

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.

Ensure that you return the Referral Form & Consent Form together to: -

Administration
People 1st Programme
PO Box 141
Northbridge WA 6865
Telephone: (08) 9227 6414
Fax: (08) 9227 6871



People 1st Programme

Referral Form

1. **Is the person being referred:**

A child under 18

An Adult over 18 years

2. **Details of person being referred:**

Name: _____

D.O.B.: _____

Gender: _____

Address: _____

Postcode: _____

Phone Number: _____

Mobile Number: _____

Country of Birth: _____

Language spoken: _____

Aboriginal / Torres Strait Islander: Yes / No

Current School Attended: _____

Contact Number: _____

Current Day Occupation / Activities: _____

Contact Number: _____

3. a) If the client is over 18 years old, do they have a Legal Guardian appointed by the State Administrative Tribunal? Yes No

Name of Legally appointed Guardian: _____

Contact Number: _____

- b) If the client is under 18 years old,

Name of Legally Appointed Guardian: _____

Contact Number: _____

4. **Details of Person Referring:**

Name: _____

Address: _____

_____ Postcode: _____

Phone Number: _____ Mobile: _____ Fax Number: _____

e-mail Address: _____

5. **Details of Parent / Carer or Guardian:**

Name: _____

Address: _____

_____ Postcode: _____

Phone Number: _____ Mobile: _____ Fax Number: _____

e-mail Address: _____

6. **Other Person(s) / Agency(s) involved at the current time:**

1) _____ Contact Number: _____

2) _____ Contact Number: _____

3) _____ Contact Number: _____

7. **Please indicate the Day(s) available to attend sessions:**

Mon Tue Wed Thurs Fri

AM

PM

CLIENT INFORMATION:

8. **Please specify the Diagnosis of Disability:**

9. **Reason for Referral:**

9. **Please indicate **FOUR** areas that you would like to talk about in the sessions:**

- | | |
|---|--|
| <input type="checkbox"/> Promoting Self Esteem | <input type="checkbox"/> Dealing with Menstruation |
| <input type="checkbox"/> Developing and Maintaining Friendships | <input type="checkbox"/> Dealing with Masturbation |
| <input type="checkbox"/> Bullying / Teasing | <input type="checkbox"/> Safer Sex Practices |
| <input type="checkbox"/> Protective Behaviours | <input type="checkbox"/> Methods of Contraception |
| <input type="checkbox"/> Engaging in Healthy Relationships | <input type="checkbox"/> Decisions relating to Pregnancy |
| <input type="checkbox"/> Puberty | <input type="checkbox"/> Same Sex Relationships |
| <input type="checkbox"/> Personal Hygiene | <input type="checkbox"/> Cyber Safety |

10. **Additional Information**

Does the person being referred have any of the following?

Behaviours of Concern: Yes / No Brief details: _____

The Behavior Management plan **MUST** be included.
(Describe what you do to manage incidents/outbursts) _____

Diagnosed Mental Health Issues: Yes / No Brief details: _____

Any Current suicidal thoughts: Yes / No Brief details: _____

Currently receiving services or recently had involvement with the Justice System: Yes / No
Brief details: _____

Currently receiving services from the Department for Child Protection: Yes / No
Brief details: _____

The above will not discount people from receiving a service but, the information provided, enables us to allocate the person more appropriately improving the quality of the service delivered.

Consent Form

PLEASE ENSURE THE CONSENT FORM IS SIGNED BY THE CLIENT AND THE PARENT/GUARDIAN IF THE CLIENT IS UNDER 18.

I, _____ (Client's Name)

am willing for the information to be discussed with the following people:

(1) Name: _____ Phone Number: _____

Organisation: _____

email Address: _____

(2) Name: _____ Phone Number: _____

Organisation: _____

email Address: _____

(3) Name: _____ Phone Number: _____

Organisation: _____

email Address: _____

Privacy Information

People 1st Programme respects your privacy. Your information will be kept private and only discussed with your agreement **EXCEPT** where the law says we have to share information.

* Signature of Person being referred _____

* Signature of parent / legal guardian for people under the age of 18 years _____

Date: _____