



REFERRAL PROCEDURE

for the

PEOPLE 1ST PROGRAMME (P.I.P.)

LOWER GREAT SOUTHERN

'Supporting People with an Intellectual Disability in Self Esteem Human Relationships, Protective Education and Sexuality'

Before a person can gain access to any of the services offered by the People 1st Programme, **IT IS ESSENTIAL** that the attached **Referral (pg 2 & 3) and Client Consent (pg 4) Forms** are completed and that conditions, as detailed below, are fully understood.

Access to the **People 1st Programme** is voluntary and based upon the idea of informed consent. **It is very important** that all potential clients will:

- **have the reasons for referral and possible participation fully explained**
- **have the contents of the forms fully explained and**
- **be willing participants**

If any of these conditions present particular difficulties, please contact PIP's Manager, who will be more than happy to assist wherever possible, with their resolution.

On receipt of **all** forms contact will be made with the applicant and/or the referral person/support person to arrange a convenient time for the first appointment.

FEES:

All people wishing to obtain PIP services, must pay an annual membership fee to the Programme on their **first** visit.

This is

\$33.00 for 12 months for people under 16 years of age

or

\$44.00 for 12 months for people 16 years and over.

This fee is only paid once a year and people can return to PIP for as many one-to-one educational services as they need during that time.

NOTE: IF UNDER 18 YEARS OF AGE IT IS A REQUIREMENT THAT PARENT(S) OR LEGAL GUARDIAN(S) CONSENT TO THEIR CHILD ACCESSING SERVICES & SIGN ATTACHED FORM.

If you require further information, please do not hesitate to contact
The **PIP** Team on (08) 9227 6414

PEOPLE 1ST PROGRAMME (P.I.P.)

Perth

'Supporting People with an Intellectual Disability in Self-Esteem, Human Relationships,
Protective Education and Sexuality'

REFERRAL FORM FOR SERVICES

Name of Client : _____ **D.O.B.** _____

Address: _____

_____ **Postcode:** _____

Phone Number: _____ **Mobile Number:** _____ **Gender:** _____

Country of Birth: _____ **Aboriginal or Other:** _____

Main Language spoken at home: _____

Day Occupation/Activity: _____ **Contact Number:** _____

Primary care giver(s): _____ **Contact Number:** _____

Person referring: _____

e-mail Address: _____

Address: _____

_____ **Postcode:** _____

Phone Number: _____ **Mobile:** _____ **Fax Number:** _____

Reason(s) for referral:

2. List the names of any other agencies or person(s) who are currently providing any services or support:

1) _____ **Contact Number:** _____

2) _____ **Contact Number:** _____

3) _____ **Contact Number:** _____

3. Please tick (4) below any subjects or areas which you might like to talk about in educational sessions.

- | | |
|--|---|
| <input type="checkbox"/> Feelings | <input type="checkbox"/> Sexual health education |
| <input type="checkbox"/> Self esteem | <input type="checkbox"/> Pregnancy & Parenting |
| <input type="checkbox"/> Friendship skills | <input type="checkbox"/> Personal Hygiene |
| <input type="checkbox"/> Relationships | <input type="checkbox"/> Puberty |
| <input type="checkbox"/> Social skills | <input type="checkbox"/> Masturbation |
| <input type="checkbox"/> Bullying & Teasing | <input type="checkbox"/> Menstruation |
| <input type="checkbox"/> Understanding Personal Safety | <input type="checkbox"/> Body awareness |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Contraception |
| <input type="checkbox"/> Choices & responsibilities | <input type="checkbox"/> Couple education |
| <input type="checkbox"/> Safe Sex | <input type="checkbox"/> Challenging Behaviour(s) |
| <input type="checkbox"/> Other | |

4. Other details which might assist us when beginning education services:

Date: _____

**** Client Consent Form must be signed by the client and sent with this form ****

CLIENT'S CONSENT FORM

I, _____ [client's name]

give permission for the 'PIP' Referral form to be completed by:

_____ [service provider or parent]

and for this information to be discussed with 'PIP' Staff, the Referrer and the below person (s)
(i.e. people who support participant at home, work, school or in the community etc.)

Person / Agency (1) _____

e-mail / Postal Address: _____

_____ **Postcode:** _____

Phone: _____ **Mobile:** _____

Person / Agency (2) _____

e-mail / Postal Address: _____

_____ **Postcode:** _____

Phone: _____ **Mobile:** _____

PRIVACY INFORMATION

PIP respects your privacy. Your information will be kept private and only be discussed with PIP staff and the people named on this form (except where the law says we have to share information). You have the right to access information about you and let us know of any changes.

I HAVE HAD THE INFORMATION ON THE REFERRAL FORM EXPLAINED TO ME. I UNDERSTAND THE PRIVACY INFORMATION AND AGREE TO ATTEND THE FIRST APPOINTMENT.

Signature of participant:

Signature of service provider or Signature of parent(s)/ legal guardian(s) for people under 18 years

Date: _____

(This form **must** accompany the **People 1st Programme Referral form**)

**Please return forms to: People 1st Programme Administration
PO Box 141, Northbridge WA 6865**

*PLEASE DO NOT HESITATE TO CONTACT THE PIP MANAGER
ON: (08) 9227-6414 IF YOU REQUIRE ANY ADDITIONAL INFORMATION OR ADVICE ABOUT YOUR PRIVACY OR
COMPLETING REFERRAL AND CONSENT FORMS.