Supportive Care Counselling

ABN 49319388902

Registered Provider No. 4050020515

PARTICIPANT REFERRAL FORM FOR INDIVIDUAL COUNSELLING
(Line Item 15_043_0128_1_3)

PARTICIPANT'S INFORMATION	REFERRED BY
Name:	Name:
Address:	Organisation:
Phone:	Role in Organisation:
Date of Birth:	Phone:
Email:	Email:
NDIS Number:	Reason for Referral: (Presenting problem)
Plan Dates:	
Is participant: Plan managed ☐ Name of Plan Manager/email for invoices: Self-managed ☐ Agency Managed ☐	
Estimated Budget for Sessions:	Participant's Goals: (Attach NDIS plan if relevant)

Primary Carer's Name:
Relationship to Participant:
Emergency Contact:

Preferred Location for Counselling Sessions: (In Home, In Office, Residential Facility, Group Home, Nearby café)
Known Home Hazards/Precautions if Sessions Conducted at Participant's Home: (Eg. Dogs, access to property, other people in home)
Participant's Known Physical Medical Conditions:
Participant's Known Mental Health Diagnosis: Participant's Disclosure of suicidal thoughts or suicide attempts in the past four weeks: Participant's Current Support Network: (E.g. Support workers, carers, family, health practitioners)
GP Name: Phone: Medical Centre:

For further information contact: Sonya Cavanough: Director of Counselling Services
Email: sonya@supportivecarecounselling.com.au Phone 0414 487 389

ndis REGISTERED PROVIDER