REFERRAL FORM

We have immediate availability for Counselling Services. For any urgent referrals, please call NPBS on 1300 28 29 40 to discuss our capacity.

We have a pre-intake process that takes approximately 30 minutes, which will be required prior to accepting this referral

Please note - the wait period begins from when we receive all relevant documentation

Once you have filled this form, please email it to support@nationalpbs.au

Risk Analysis of Participant

Is there a risk of harm to our Therapist? *

◯ Yes ◯ No

Details of risk of harm to our Therapist. *

Please enter short details on risk of harm to our Therapist.

Does the participant have any history of Drug or Alcohol abuse? *

◯ Yes ◯ No

Details of history of Drug or Alcohol abuse. *

Please enter short details on history of Drug or Alcohol abuse.

Are you aware of any" Triggers" for this participant that may result in a violent/aggressive response? *

◯ Yes ◯ No

Details of any" Triggers" for this participant that may result in a violent/aggressive response. *

Please enter short details on any" Triggers" for this participant that may result in a violent/aggressive response.

Does the participant have any history of violence towards support staff or health professional? *

◯ Yes ◯ No

Details of any history of violence towards support staff or health professional. *

Please enter short details on any history of violence towards support staff or health professional.

Does the participant experience any active symptoms of Psychosis? *

◯ Yes ◯ No

Details of any active symptoms of Psychosis? *

**Depending on the type of circumstances discussed on the initial intake, we may not be able to provide serivces.*

Participant details

Participant full name *

Please enter the name of the participant

NDIS number *

DOB *

dd/MM/yyyy

Start date of plan *

dd/MM/yyyy

Plan review date

dd/MM/yyyy

End date of plan *

dd/MM/yyyy

Address of participant

Street Address

Suburb *Post code*

State

Is this participant living in a residential aged-care facility? *

◯ Yes ◯ No

Consent

Is the participant over 16 years old? *

- ◯ Yes
- ◯ No

Has the participant/nominee given consent for this referral? *

- ◯ Yes
- ◯ No

Please ensure that you have consent from the participant or nominee to make this referral

Participant preference of gender of therapist

- ◯ Either
- ◯ Female
- ◯ Male

Does participant have a nominee, or are they their own decision-maker? *

- ◯ Has nominee
- ◯ Own decision-maker

Email address and phone number of participant

Name of nominee *

Relationship to participant

Email address of nominee

Nominee phone number

Are you happy to engage in Tele Health Services? *

- ◯ Only during covid
- ◯ At all times
- ◯ Face to face meetings only

Support

Are you happy to engage in Tele Health Services? *

- ◯ Yes
- ◯ No

Does the participant give permission to speak to the key carer? *

- ◯ Yes
- ◯ No

Name of key carer *

The person who knows the participant the best

Key carer phone number

Key carer email address *

If participant attends a school or day program, please provide details of name of program and contact person:

Professionals involved

- [ ] Occupational therapist
- [ ] Speech pathologist
- [ ] General Practitioner
- [ ] Psychologist
- [ ] Psychiatrist
- [ ] Physiotherapist
- [ ] Podiatrist
- [ ] Dual Diagnosis specialist
- [ ] Dietician
- [ ] House manager
- [ ] Other

Details of Occupational Therapist *

Please provide Name, Phone Number and Email

Details of Speech Pathologist *

Please provide Name, Phone Number and Email

Details of General Practitioner *

Please provide Name, Phone Number and Email

Details of Psychologist *

Please provide Name, Phone Number and Email

Details of Psychiatrist *

Please provide Name, Phone Number and Email

Details of Physiotherapist *

Please provide Name, Phone Number and Email

Details of Podiatrist *

Please provide Name, Phone Number and Email

Details of Dual Diagnosis specialist *

Please provide Name, Phone Number and Email

Details of Dietician *

Please provide Name, Phone Number and Email

Details of House manager *

Please provide Name, Phone Number and Email

Details of Other Professionals *

Please provide Name, Phone Number and Email

Behaviour / Diagnoses / Risk

Clinical diagnosis/diagnoses

Brief description of client/behaviours of concern/reason for referral

Funding

How many hours of funding is allocated to NPBS for Counselling services? *

Plan managed, Self Managed, or NDIA managed? *

Details of where invoices to be sent

Email address, detail of plan manager etc

Person filling out referral form

Referrer name

Your name

Referrer organisation

Referrer contact number

Referrer email *

How did you hear about us?

☐ I declare that the information provided is accurate. I understand that any information that is not revealed at the time of referral that puts therapists at risk or is beyond initial complexity indicated, may result in National PBS withdrawing services.
*

Date

dd/MM/yyyy

We will be in contact regarding your response as soon as possible. (1 to 2 Business Days).
Please note - the wait period begins from when we receive all relevant documentation.