Behaviour Support
Referral Form

Referral Details				
Referral Type:	☐	Self-referral (including supported completion)	**Date:**	
	☐	Referral on participant's behalf		
Funding Type:	☐	NDIS (attach funding plan)		
	☐	Other, please specify:		

Please detail any behaviours of concern this referral is seeking to address:				
Is there an existing Behaviour Support Plan in Place?	☐	Yes, expiry date:		
	☐	No		
Are restrictive practices being used?	☐	Yes	☐	Authorised
			☐	Unauthorised
	☐	No		

Referrer Details			
Name (first, last):		**Relationship to the participant:**	
Contact Number:		**Email:**	
Organisation (where applicable)**:**			
Has the participant been made aware of the referral?	☐	Yes	
	☐	No	
Is the participant aware of other service options/providers that might be available to them?	☐	Yes	
	☐	No	
Please list any alternative referral options that were provided to the participant:			

Participant Details (if this is a referral for an existing Uniting WA participant, these details do not need to be provided here)			
Name (first, last):		**Preferred name/s (if applicable):**	
Gender / Preferred pronouns:		**Date of Birth:**	

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Residential Address:			
Suburb:		**Post code:**	
Email:		**Phone Number:**	
Do you identify as being Aboriginal or Torres Strait Islander?	☐ Yes		
	☐ No		
Is your main language a language other than English?	☐ Yes		
	☐ No		
Do you require an interpreter?	☐	Yes, please specify language:	
	☐	No	

Preferred / Additional Contact Information

Is there a preferred contact person for us to contact, other than the participant?	☐	Yes	**Is there a contact person for us to contact, in addition to the participant?**	☐	Yes
	☐	No		☐	No
Preferred contact name:					
Preferred contact number:					
Preferred contact relation to participant:					

Decision Making Support

Informal Decision-making Support Person/s (family members, carers, other):

Name:	Phone Number / Email:	Relation to Participant:

Formal Decision-making Support:

Does the participant have any of the following in place:	☐	Guardianship Order / Enduring Guardian
	☐	Enduring Attorney
	☐	Advance Health Directive
	☐	Advance Care Plan

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Do any supported / substitute decision-makers need to be contacted in relation to this referral and/or the services to be provided?	☐	Yes, provide detail below.
	☐	No

Name:		**Phone Number / Email:**	
Relation to Participant:		**Must be contacted if/when:**	

Name:		**Phone Number / Email:**	
Relation to Participant:		**Must be contacted if/when:**	

Additional Information

Is the participant receiving other NDIS services?	☐	Yes, please detail:	
	☐	No	
Are there any known risk indicators?	☐	Yes, please detail:	
	☐	No	
Does the participant have a diagnosis? If yes, please detail:			

Consent

By submitting this completed Form, the participant gives, or has given, consent for the information included within the Form to be provided, and for Uniting WA to contact and/or seek additional information in relation to the provision of our Behaviour Support Services from those identified on this Form.

Participant/Decision-makers' Name:			
Signature:		**Date:**	