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| **Healing Through Arts**  *A means to healing & growth …* **Date of Referral:**  | **REFERRAL FORM**admin@htatherapy.com M:0423 748 060If client under 16 years, have they consented to referral? □ Yes □ No |
| **Clients NDIS Number:**   **Support Plan dates**: If applicable  |
| □ Self-Managed□ Plan-Managed□ Private | *(If Plan Managed)*Plan Manager: Email: Phone:  |
| **CLIENT NAME:**  | DOB: | Gender: □Male □Female □ Other/Specify |
|
| **CLIENT ADDRESS:** | Client Phone: Client Email:  |
|
| **SUPPORT CO-ORDINATOR NAME:**  | PH:  | Email:  |
| **Please Describe the Living Arrangements:** * Lives Alone
* Lives with Family
* Supported Living
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | Is there a contact for the living arrangement? Name: Ph:  |
| **EMERGENCY CONTACT NAME:** | **RELATIONSHIP:**  |
| **CONTACT PHONE:**  |
| **REFERRER DETAILS**  Name: Organisation and Position: Phone: Email: |
|  **REFERRAL SERVICE:** **NDIS Non NDIS (Private)** □ **Capacity Building □ Core** □ Therapeutic Supports □ Participate in Community □ Innovation Community Participation □ Development-Life Skills □  |
| **DETAILS FOR REFERRAL**Reason for referral and expected outcomes? **History of client**Please note: Please include sufficient and all relevant information in your referral to avoid us contacting you needing further details Diagnosis’:   Allergies:  Risks: (please complete) Known Triggers and strategies used:Family Dynamics: Indigenous/Cultural Identity: |
| **Client details for Art Therapy**Strengths: Interests: Dislikes:Challenges:   **Please provide a copy of the participants NDIS Goals (if applicable) along with referral:****Preferred location for Art Therapy:**□ Precinct Wellbeing Hub Smithfield Plains SA□ Home Visit (if Therapist available)□ Online Art Therapy Session   |