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| --- | --- | --- | --- | --- | --- |
| **Healing Through Arts**  *A means to healing & growth …*  **Date of Referral:** | | | **REFERRAL FORM**  [admin@h](mailto:admin@h)tatherapy.com M:0423 748 060  If 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 | | | | |