INTERACTION
Empowering People

Date:

BEHAVIOUR & ALLIED HEALTH SERVICES FORM

Due to the exceptional standard of Interaction's Behaviour and Allied Health Services team the demand is always high. By completing the referral form, you will be assured of an efficient and timely response by a Behaviour & Allied Health Services representative, who will discuss your referral further. Alternatively, you are welcome to call us on 1300 668 123 or email alliedhealth@interactionservices.org .

Name:	☐ M ☐ F	**DOB:**
Living Arrangements:	☐ With Family ☐ On Own ☐ Group Home ☐ Other	
	If Other, please specify:	
Address:		
Phone:		**Alternate Phone:**
Email:		

Diagnosis/Disability (including mental health diagnoses):	
Specific Medical Needs/Conditions:	
Ethnic Background:	
Language Spoken:	
Interpreter Required:	☐ Yes ☐ No
Currently Attending:	☐ Preschool ☐ Mainstream School ☐ Special School ☐ Day Program ☐ Other
	If Other, please specify:
Employment:	☐ Supported Employment ☐ Open Employment ☐ Other
	If Other, please specify:
Communication:	☐ Verbal ☐ Non-Verbal ☐ Augmentative ☐ Other
	If Other, please specify:
Are you completing this form as:	☐ The Participant ☐ Parent/Persons Responsible ☐ Support Coordinator ☐ Guardian ☐ Other
If Parent/Person Responsible:	Name:
	Address:
	Organisation:
	Phone/Mobile:
	Email:
Is the participant able to consent to making the referral?	☐ Yes ☐ No

NDIS Plan Details:	☐ Participant has NDIS Plan ☐ Participant does NOT have NDIS Plan

NDIS services can only be provided if you have an NDIS Plan. Alternatively we can provide Behaviour and Allied Health Services within our Consultancy (fee for service) category, as well as Medicare.
Please provide details of your requirements in the box below and Interaction's Behaviour and Allied Health Services Team will contact you to discuss your requirements.

If you have an NDIS Plan, please continue -		
Plan date:	Start:	End:
Plan Number:		

Support Categories -	
Improved Daily Living:	☐ Yes ☐ No **Amount: $**
Improved Relationships:	☐ Yes ☐ No **Amount: $**
Goals:	

Support System -	
Does the Participant currently have services in place?	☐ Yes ☐ No
What Services:	☐ Occupational Therapist ☐ Behaviour Support ☐ Psychiatrist ☐ Speech Pathologist ☐ Psychologist ☐ Paediatrician ☐ Counsellor ☐ Physiotherapist ☐ Other
	If Other, please specify:

Presenting Issues -	
What are the Primary presenting issues requiring support? (List most serious behaviours of issues)	
What is the impact of the situation on family, support system and others?	
Restricted Practices?	☐ Yes ☐ No ☐ Unsure
	If Yes, please specify:

Risks -	
Please tick any boxes that relate to the current referral:	☐ Verbal aggression ☐ Transition phase ☐ Could lose placement ☐ Physical aggression ☐ Death of significant other ☐ No clinical support ☐ Injury ☐ Substance abuse ☐ Recent hospitalisation ☐ Sexual ☐ Mental Health ☐ Police involvement

Expected Outcomes -		
Expected outcomes from service:		
Expected timeframe for receiving service?		
Location of service to be provided (multiple locations can be selected):	☐ IDS Office ☐ Family Home ☐ Own Home ☐ Group Home ☐ Daycare ☐ Respite/Day Program ☐ School ☐ Other	
	If Other, please specify:	
Primary Contact Person/ Primary decision maker:	☐ The Participant ☐ Parent/Persons Responsible ☐ Guardian ☐ Other	
	Name:	
	Phone:	Alternate Phone:
	Email:	
	Address:	

How did you become aware of Interaction Behaviour & Allied Health Services? -
☐ Existing client for other services ☐ Facebook Interaction Page ☐ Facebook Interaction Prader-Willi Syndrome Page ☐ Facebook Other ☐ Interaction Website ☐ Prader-Willi Syndrome Webpage ☐ Advertisement ☐ Referral ☐ Other
If Advertisement, Facebook Other or Other, please specify:
Do you consent to being added to Interaction's bi-monthly electronic newsletter? ☐ Yes ☐ No

Consent -	
This information will be used to inform allocation of support, and will be stored securely by Interaction's Behaviour and Allied Health Services team. Should you decide not to choose Interaction, your hard copy documentation will be destroyed. Please notify the team if you would like your soft copy files destroyed also. Otherwise, soft copy files will be retained should you access our service in the future.	
Are you:	☐ The Participant ☐ Parent/Persons Responsible ☐ Guardian
Name:	
Date:	
Contact:	