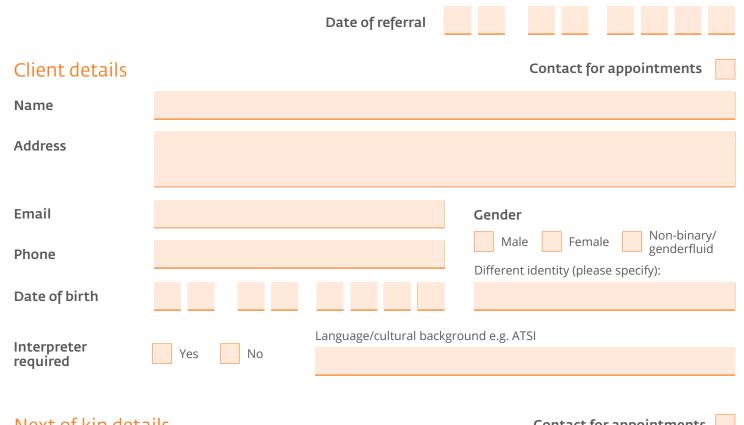


Referral Form Sexuality Services



Next of kin details		Contact for appointments		
Name				
Address				
Email		Phone		

GP details

Name		
Clinic name	Phone	
Address		



Funding details

Participant number (if relevant):		Self-fu Other fund	inding NE ing (please specify	
Approval attached	or, quote required			
NDIA (agency managed	d) Self managed Plan managed			
Plan Manager name:				
Email		Phone		
If icare / Compensable				
Contact person				
Address				
Email		Phone		
Support coordinat	cor / Case manager details		Contact for ap	pointments
Name				
Service				
Address				
Email		Phone		

Primary disability / Impairment / Relevant health information:

Uses alternative augmentative device



Does the client have any of the following diagnosis:

Cardiovascular disease	Yes No	Details:	
Diabetes	Yes No	Details:	
Mental Health	Yes No	Details:	
Positive Behavioural Support Plan	Yes No	Details:	

Current medications

Reason for referral

Interventions already tried / Outcome

Safety issues / Concerns / Client risks



Phone: 9808 9205 or 1800 518 180 Fax: 8088 4783 Email: sexuality@royalrehab.com.au Website: royalrehablifeworks.com.au

NDIS / My plan g	joals		Attached	Yes No	
Referrer details			Contact for ap	pointments	
Name					
Service					
Address					
Email		Phone			
Consent obtained for referral?	Yes No Yes No Yes Yes No Yes No Yes Yes No Yes	′es No	Approx. date of	discharge	
Other relevant contacts / Service providers for client					
Name					
Service					
Email		Phone			
Name					
Service					
Email		Phone			
Name					
Service					
Email		Phone			