

10. **Approximate Length of time in this accommodation:**_____

11. **Type of Disability:**_____

12. **Please specify any special conditions because of the disability: (eg: hearing, visual, mobility, feeding, concentration, toileting)**

13. **Is client registered with Disability Services Commission? YES NO**

14. **Are there any medical conditions you think we should know about?**

15. **Medication Profile:** (please list any medications currently being prescribed dosage and reason for use)

Name of Medication	Dosage	Reason

16. **Main method of communication:** (Effective means client must be able to communicate more than just basic needs to unfamiliar people using the method)

- Little or NO EFFECTIVE communication
- Sign Language or other EFFECTIVE non-spoken communication
- Spoken language EFFECTIVE

17. **Main Language Spoken** (If living in a disability specific accommodation (eg: group home, hostel, etc) refer to the language spoken in the prior family home).

18. **Type of Day Activity:** (Please tick **all** that apply)

Education:

- | | |
|---|---|
| Pre-primary/Kindergarten <input type="checkbox"/> | Education Support School <input type="checkbox"/> |
| Mainstream School <input type="checkbox"/> | TAFE <input type="checkbox"/> |
| Education Support Unit <input type="checkbox"/> | University <input type="checkbox"/> |
| Education Support Centre <input type="checkbox"/> | |

Alternatives to Employment

- Recreation
- Rehabilitation

Home:

- Home duties
- Retired

Employment:

- Open Employment
- Supported Employment
- Sheltered Employment

Length of time in employment

- Unemployed & seeking employment
- Seeking Day Placement
- Nor formal day activity
- Other
(Please specify)

19. Reason for Referral: (Please be as detailed as possible)

20. Has client attended education/counselling sessions previously?(please specify)

Part Two:

CLIENT'S PRIMARY SUPPORT PERSON/CARER DATA

1. Name(s): _____
2. Address: _____
_____ **Post code:** _____
3. Contact Phone Number: _____ **Mobile:** _____
4. Email Address: _____
5. Relationship to Client: _____

Part Three:

REFERRING PERSON'S DATA

1. Name: _____
2. Position: _____
3. Agency: _____
4. Contact Phone Numbers: _____ **Mobile:** _____
5. Email Address: _____
6. Relationship to Client: _____
7. How did you learn about secca: _____

Part Four:

CONTACT PERSON TO ARRANGE APPOINTMENT

1. Name of person to contact:(regarding appointment)_____

2. Relationship to Client:_____

3. Address:_____

4. Contact Phone Numbers:_____ Mobile:_____

5. Email Address:_____

6. Please note if there are any special times the person is available to be contacted:

7. Are there special times the person is available to be seen by a counsellor?

8. Will Client be attending secca independently? Yes No

9. If no, who will be accompanying Client?_____

Name(s):_____

Address:_____

_____ Post code:_____

Contact Phone Number:_____ Mobile:_____

Email Address:_____

Relationship to Client:_____

10. If yes, which mode of transport will be used?_____

Part Five:

CONFIDENTIALITY STATEMENT

We will treat all information provided by you as confidential and will ensure all records provided to us are kept in a secure manner and available only to those persons authorised to have access to them.

Thank you for completing the Referral for Services. To enable processing,

**Please post to secca
City West Lotteries House
2 Delhi Street
West Perth WA 6005**

Or Fax: (08) 9420 7229

Or E-mail: admin@secca.org.au