KEVIN HEINZE Grow
39 Wetherby Road, Doncaster 3108 VIC
(03) 9848 3695
info@kevinheinzegrow.org.au
www.kevinheinzegrow.org.au
ABN: 63 073 435 291

KHG Therapeutic supports referral form

*The section marked "*****" must be completed. Please send the completed referral form to* ***clientservices@kevinheinzegrow.org.au*** **.** *We will be in touch with you as soon as possible. All information we collect will be treated confidentially and will not be used for any other purposes than what is stated on our confidentiality and privacy statement.*

Referral details*			
Date of referral		Does the individual know and consent to the referral? ☐ Does the guardian or family member consent to this referral? ☐	
Name of person completing the referral:		Relationship to Participant:	
Email:		Phone:	

Participant's details*				
Name:	**DOB:**		**Gender**	
Residential Address: Suburb: Postcode:		Phone: Email:		

Culture and Identity:

Does the person identify as:

☐ Aboriginal ☐Torres Strait Islander ☐ Both ☐CALD ☐LGBTIQ+ ☐Veteran

Preferred pronouns:

Country of birth:

Language:

Education:

Mainstream ☐ Special development education ☐

Primary ☐ Secondary ☐ Other ☐

Communication preferences:

Spoken ☐ written ☐ visuals ☐ gesture/ body language ☐ communication device ☐

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Diagnoses:

What is the individual's preference related to their diagnosis: ie. 'autistic person' or 'person with autism', other?

Does the individual have any sensory preferences? Eg. Quiet spaces, low lighting etc.

Reason for referral * -	☐ OT ☐ Speech therapy ☐ Counselling ☐ Art therapy ☐ Therapeutic groups – Re Grow, other

Has the individual seen an allied health professional before – please tick OT ☐ Speech therapy ☐ Counselling ☐ Art therapy ☐

What has been the focus/ goals of these sessions?

Are there any reports from these sessions? Yes ☐ No ☐
Can copies be provided? Yes ☐ No ☐

What are the individual's general interests/ hobbies?

Do they like being outside? Yes ☐ No ☐

What motivates them?

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Which site does the individual want to attend?	**Doncaster/Coburg**

Funding body:	☐ NDIS ☐ Self-funded ☐ TAC ☐DEET ☐ Other (please specify)

If you are funded through TAC or other organisations, please provide your customer number or reference number if applicable.

Customer number or reference number:

NDIS plan details

NDIS Number:

Plan start date:

Plan end date:

Funding details

☐ Core supports ☐ Capacity Building
☐ Other (please specify)

Contact details

Name of NOK/Emergency Contact*:	Relationship*:	Email*: Phone*:
Name of support coordinator*:	Organisation*:	Email*: Phone*:
Name of NDIS plan manager:	Organisation:	Email: Phone:
Name of financial intermediary or funding coordinator:	Organisation:	Email: Phone:
Name of Key support worker/carer:	Organisation:	Email: Phone:
Email address for KHG announcements:		