

GAS – Referral Form (Intake)



Participant contact Information

Your name	
Preferred name	
Date of birth	
Gender / Pronoun	
Interpreter Required YES/NO (Language)	
Phone	
Email	
Address	
Postal (if different)	
Can we safely send an SMS or email to these contact details? Yes/ No	
Do any court orders apply to you?	
Workplace / School	
Occupation / Year level	
Your usual mode of transport (car, PT)	
How did you hear about GAS?	
When would you like to start?	

Referral information

Referral date	
Referring agency	
Contact person	
Email	
Phone	
Reason for referral	
Diagnosis / disability (if applicable)	

Emergency contact information

In case of emergency please contact (Parent, Guardian, Advocate, Agency, Friend)	
Name	
Phone	
Email	
Address	
Relationship to you	
Have they been informed of this role YES/NO	

Billing information

Funded by (send invoice to)	
NDIS Disability Care Number (if applicable)	
NDIS Plan end date	

Support needs

What brings you to GAS?	
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Do you have any other support right now?	
Do you have any specific needs regarding your culture, gender, religion?	
Which GAS activities interest you most?	

Safety needs

Do you have a Safety Plan?	
Do you have a Behaviour Support Plan?	
Can you communicate unaided?	
Do you require mobility aids?	
Do you require personal care assistance?	
Can you self-administer medication?	
Are you able to understand and follow safety instructions?	
Are you comfortable in outdoor environments?	
Are there any places or activities we should avoid?	
What strategies do you use to calm and regulate your nervous system? Do you need assistance?	
Do you have difficulty with specific triggers?	
Have you deliberately injured or harmed yourself?	
Have you experience suicidal ideation?	
Have you been verbally or physically violent towards others?	
Have you ever absconded whilst in care?	
Do you have a heightened interest in fire or pose a fire risk?	
Are you able to attend free from alcohol and/or illicit drugs?	
Is there anything else you would like GAS staff to know (in regard to keeping you safe)?	

Medical history

Medicare number	
Medicare expiry date	
Private Health Insurance YES/NO	Ambulance cover YES/NO
Are you vision impaired? YES/NO	Are you hearing impaired? YES/NO
Do you have asthma? YES/NO	Do you have an Asthma Action Plan? YES/NO
Do you have diabetes? YES/NO	Do you have a Diabetes Management Plan? YES/NO
Do you have epilepsy? YES/NO	Do you have an Epilepsy Management Plan? YES/NO
Do you have allergies? YES/NO	Do you have an Allergy or Anaphylaxis Action Plan? YES/NO
What are you allergic to?	
Do you have a heart condition? YES/NO	Do you have any problems with your balance? YES/NO
Do you have any back, knee, ankle, shoulder problems?	
Has a doctor placed any restrictions on your activity?	

How far or for how long can you walk without stopping?	
How far can you swim without stopping?	
Please list all other medical conditions and illnesses.	
Instructions for GAS staff (if applicable).	

Medications

Name of medication	Dose	Frequency	Purpose of medication

Other contacts

General Practitioner	
Full name	
Clinic name	
Address	
Phone	
Email	

Psychiatric Practitioner	
Full name	
Their role (Psychiatrist, GP, other)	
Clinic name	
Address	
Phone	
Email	

Support Coordinator / Key Worker / School	
Full name	
Their role	
Agency	
Address	
Phone	
Email	

CONSENT TO EXCHANGE INFORMATION

Full name of client:

Limitations to confidentiality

All interactions which take place during GAS support are considered confidential. This includes requests by telephone, all interactions with GAS staff & the group, any scheduling or support notes, all session content records and any progress notes that are recorded during sessions. However, there are some limitations regarding this, and GAS staff will be required to break confidentiality under the following circumstances:

- Discussing with other GAS staff members for supervision or administration
- If you are in immediate danger to yourself or others
- If you have abused a known minor
- You disclaim to the staff member that you intend to commit a crime in the future
- Laws for mandatory reporting on specific abuses
- Reporting to other agencies for funding and ongoing support i.e. NDIS
- You sign a release or verbal permission is given to GAS
- If the court system requests a subpoena from GAS for your records

Collaboration with other services regarding our work

Occasionally at GAS we may need to contact other agencies and practitioners related to your care with us.

- Referring Agency
- General Practitioner
- Psychiatric Practitioner
- Support Coordinator / Key Worker / Plan Manager / School

Please list any additional practitioners and/ or agencies we may need to be in contact with during your GAS support in the following table:

Name	Agency	Support Provided	Contact Details

I, _____ (full name) understand the limitations of confidentiality at GAS and I give consent for GAS to collaborate with the practitioners listed above.

Signature:

Date: