

Initial Referral Form

Person being referred

First name:		Age:	
Gender: □ Female □ I	Male □ Other		
Cultural Diversity: Aborigi	nal & Torres Strait Islar	nder	specify)
Usual living arrangements (In	dependent/Service pro	ovider Other):	
Employment and/or day activ	/ities:		
Communication: □ Verbal	☐ Sign Language	☐ Assistive Technology	□ Other (please specify)
Primary Diagnosis:			
Reason for referral:			
Outcomes for Person What would you like to see h	appen as a result of th	is Service Provision in Speci	ialist Behaviour Support?
Referral Source			
□ Next of kin/Guardian	☐ Coordinator of S	Supports Other	
Referrer Contact name:			
Position/relationship:			
Organisation (if applicable):			
Phone:		Email:	
Service Required (tick all tha	t apply)		
☐ Assessment ☐ Interim E	BSP □ Comprehensiv	ve BSP Restrictive Pract	tice Authorisation Report
Preferred Commencement da	ate: / /		



Person Insights

This inforr being refe	•	rovided to ensure	Pixe PBS car	assess the	service pro	ovision requ	irements of the person	1
Does the I	person have a his	tory of sexual abu	ise or sexual	acting out?	□ Yes	□ No	□ Unknown	
Does the I	person have beha	aviours of concern	ı? □ Yes	□ No)l	Jnknown		
Are restric	ctive measures us	sed? □ Yes	□ No	□ Unkno	own			
Has the po	•	d violence related	adversity?	□ Yes	□ No	□ Unkno	own (e.g. domestic	
Please ou		urs and any actior	ns including r	estrictive m	easures th	at can be ta	iken to manage the	
Does the p	person have a cu	rrent positive beh	aviour suppo	ort plan?	□ Yes	□ No	□ Unknown	
	-	k to themselves o	•		ork, service □ No	e or commu	nity environment? (e. _{	5.
Does the p	person have subs	tance abuse issue	s? □ Yes	□ No	o 🗆	Unknown		
□Self	Maker Details ☐ Informal er information re	□ EPOA garding the partic	□ Public G ipant and the		□ Public ur support			
			•		.,			

Please complete this form and email to Lisa via: hello@pixe.com.au

Pixe PBS will make every effort to provide services for all referrals dependent on availability and resources.