INDIGENOUS MENTAL HEALTH PROGRAM
Client Referral and Consent Form

HealthWISE
Creating healthier communities

HealthWISE will assist you/your patient to access Mental Health Services.

Each case will be assessed based on the information provided. The level of support will be determined on a case by case basis and subject to Hunter New England Central Coast Primary Health Network (HNECC PHN) guidelines, policies and procedures and the capacity of HealthWISE staff.

- Once signed, this form will register you or your patient to become a client of the Indigenous Mental Health program run by HealthWISE.
- Registration will allow the Indigenous Mental Health team to access and share necessary information with health providers and other relevant service providers who are identified to support the client.
- All information shared between the client and HealthWISE will be strictly confidential, at all times.
- All data collected and used for reporting purposes will be de-identified.
- You or your patient will notify HealthWISE if they are being supported by another service.
- HealthWISE has a zero tolerance policy for abusive behaviour towards our staff. Any breaches of this policy may result in you or your patient being released from this program.

Please forward signed and completed forms to the HealthWISE Indigenous Mental Health team via imh.staff@healthwise.org.au.
Please call your local IMH Worker for further information:

PEEL CLUSTER LIVERPOOL PLAINS	**Blossom Pitt IMH Care Coordinator** Monday – Friday	**02 6766 1394**
TABLELANDS REGION	**Kerry Strong IMH Lead Care Coordinator** Monday – Friday	**02 5733 5308**
	Natasha Haines IMH Peer Support Worker Monday – Friday	**02 6771 1146**
	Bernise Leece First Nations Support Coordinator Monday - Friday	**02 6721 4117**

Consent

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I hereby agree to my records being kept in a secure medical software program held by HealthWISE. I acknowledge that the purpose of holding this information is to assist in the management of my mental health and used for de-identified reporting to funding providers.

Full name

DOB / / **Gender** ☐ Male ☐ Female ☐ Prefer not to say

Address **Town** **Post Code**

Phone

Regular GP **Medical practice**

Are you of Aboriginal descent? ☐ Yes ☐ No **Are you of Torres Strait Islander descent?** ☐ Yes ☐ No

This consent is subject to:

- The information retained on the medical software being kept strictly confidential.
- Any information required for research being used on de-identified data reports.
- My right to withdraw consent at any time by informing the Indigenous Mental Health Team.
- My mental health status being discussed with my GP or other health services involved in my care.

I, (full name)

understand and agree to the conditions of this consent form.

Signature Date / /

OR

I, (health professional's name) have informed (client's name)

of the conditions of the Indigenous Mental Health Program. The client has given verbal consent to these conditions.

Signature Date / /

STAFF USE ONLY - Please ensure the following are completed.
Incomplete referrals will be returned to the referrer which may prolong the referral pathway into the IMH program.

☐ HealthWISE Indigenous Mental Health Consent Form completed and signed by your patient (this form).
☐ Current mental health status and goals of engagement with the Indigenous Mental Health team.
☐ Referrer details - name, organisation and contact details.
☐ Social & Emotional Wellbeing Check - see next page
☐ Details of additional assistance needed ie support work, care coordination, group therapy support. Please fill in below.

HEAD OFFICE:
213 Peel Street
Tamworth
NSW 2340

HealthWISE
T: 02 6766 1394
E: imh.staff@healthwise.org.au
W: www.healthwise.org.au

Social & Emotional Wellbeing Check

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Reason for referral:

- ☐ **Suicide ideation/attempts**
  - ☐ History
  - ☐ Current
  - ☐ Plan
  - ☐ Intent
- ☐ **AOD misuse**
  - ☐ History
  - ☐ Current
- ☐ **Mental illness**
  - ☐ History
  - ☐ Current
- ☐ **Mandated/parole**
- ☐ **Self-harm/self-harm ideation**
  - ☐ History
  - ☐ Current
  - ☐ Plan
  - ☐ Intent
- ☐ **Family violence**
  - ☐ History
  - ☐ Current
  - ☐ Victim survivor
  - ☐ Perpetrator
- ☐ **Stolen generation issues**
  - ☐ First generation
  - ☐ Second generation
  - ☐ Third generation
  - ☐ Adoption/state ward/fostered

Significant issues/relevant information:

Purpose of referral:

- ☐ MH support
- ☐ AOD support
- ☐ BTH support
- ☐ Counselling
- ☐ IMH group therapy
- ☐ First Nations Aftercare Services (Inverell and surrounds)

What level of risk is this person? ☐ High ☐ Medium ☐ Low

Reason for risk level given:

Has a mental health plan been done for this client?	☐ Yes	☐ No
Does the client consent to the referral?	☐ Yes	☐ No
Does the client have other support services involved?	☐ Yes	☐ No
Does the client consent for IMH staff members to share information with external agencies involved in their care?	☐ Yes	☐ No

Organisation	Case Worker	Phone

Is the client happy to have their family involved with their care? ☐ Yes ☐ No

Name	Relationship	Phone

Have any/all relevant documents been attached? ☐ Yes ☐ No ☐ N/A Reason

QIC Quality Innovation Performance ACCREDITED
ABN 48 603 486 442

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