MENTAL HEALTH SERVICES
Suicide Prevention - Universal Aftercare Service & Self-Referral Form

HealthWISE
Creating Healthier Communities

Universal Aftercare is a non-clinical, free service which supports people experiencing a suicidal crisis or who have attempted suicide and Families or carers of a client impacted by suicide in New England North West of NSW.
A dedicated support coordinator will assist you to develop a personalised plan based on your needs.
Support can include:

- Creating a support plan that focuses on your long-term recovery.
- Connecting you with services, such as mental health supports, community groups, financial support, or relationship counselling.
- Making a safety plan so you know what to do and who to call if you feel distressed.
- Providing access to formal and informal support to help your recovery

HealthWISE is not a crisis service.

If you or the person being referred needs immediate support, please reach out to:

Lifeline: 13 11 14

Suicide Call Back Service: 1300 789 978

13 YARN: 13 92 76

Beyond Blue: 1300 22 46 36

MensLine Australia: 1300 789 978

Headspace: 1800 650 890

Date ____ / ____ / ____

Referral type: ☐ Self-referral ☐ Family/Friend/Carers/Kin referral ☐ Service referral

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Referrer Details (if not self-referral)

Organisation Name (if applicable):

Name

Position

Phone **Email**

Consent:

☐ I acknowledge that the person consents to this referral being made, and the information being shared with the service provider.

See next page to complete client details.

PLEASE SUBMIT REFERRAL TO
email **mental.health@healthwise.org.au** or FAX **1300 452 059**
For more information phone **1800 931 540**

QIC Quality Innovation Performance ACCREDITED
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phn HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

HealthWISE
T: 1800 931 540 **F:** 1300 452 059
E: mental.health@healthwise.org.au
W: www.healthwise.org.au

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Client Details

Full name _____ **DOB** ___ / ___ / ___

Gender ☐ Male ☐ Female ☐ Non-binary ☐ _____ **Pronouns** _____

Address _____

Town _____ **Post Code** _____

Phone _____ **Medicare number** _____

Email _____ **Date** ___ / ___ / ___

Cultural Identity: **Aboriginal** ☐ Yes ☐ No **Torres Strait Islander** ☐ Yes ☐ No

Culturally and linguistically diverse (CALD) ☐ Yes ☐ No **Do you require an interpreter?** ☐ Yes ☐ No

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Preferred method of contact ☐ Letter ☐ Email ☐ Text message ☐ Phone call

Preferred appointment type ☐ Face-to-face ☐ Telehealth ☐ No preference

Do you require an out of business hours appointment ☐ Yes ☐ No

Have you/ the person experienced or currently experiencing any of the following? Tick all that apply.

☐ Recent suicide attempt ☐ Suicidal crisis ☐ Suicidal ideation ☐ Impacted by a death by Suicide

Have you or the person recently completed a safety plan?
Please note: A safety plan belongs to the person being referred. If consent is given it is preferable that you attach the safety plan .

☐ Yes ☐ No ☐ Yes, however it requires updating

How can we help?

Are you already supported by other agencies to help you?

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