HealthWISE
Mental Health · Allied Health · Aboriginal Health

flourish AUSTRALIA
Supporting Mental Health & Wellbeing

Indigenous Mental Health Program
CLIENT REFERRAL AND CONSENT FORM

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

Each case will be assessed on the information provided and 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 the HealthWISE staff.

1. This form, once signed, will register you or your patient to become a client of the Indigenous Mental Health Program run by HealthWISE.
2. 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 overall client focused outcomes.
3. All information shared between the client, HealthWISE and Flourish AUSTRALIA will be treated as strictly confidential, at all times.
4. All data collected used for reporting purposes will be de-identified.
5. You or your patient will notify HealthWISE or Flourish AUSTRALIA if they are receiving any other assistance that supports your patient.
6. HealthWISE have a Zero Tolerance policy for abusive behavior. Any breaches of our behavior policy may result in you or your patient being released from this program.

Consent

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:_____/_____/ _____ Male / Female / Prefer Not to Say

Aboriginal / Torres Strait Islander / Both (please circle if applicable)

Address: (not PO Box)_____

Contact phone number:_____

Regular GP name & Practice:_____

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This consent is subject to:

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

Patient Signature: _____ Date:_____/_____/_____

Indigenous Mental Health Checklist

Before referring your patient to be assisted by the Indigenous Mental Health Program, please ensure that the following has been completed and is attached:

- ☐ HealthWISE Indigenous Mental Health Consent Form completed and signed by your patient
- ☐ Current Mental Health status and goals of engagement with the Indigenous Mental Health team
- ☐ Referrer details – Name , organization and contact details.
- ☐ Details of additional assistance needed i.e. Peer Navigation, Care Coordination, Group therapy support etc. *please fill in below:*

_____

_____

_____

Office use only

Please forward signed and completed form to the HealthWISE Indigenous Mental Health team on imh.staff@healthwise.org.au or please call the IMH Care Coordinator for further information:

Tamworth	Deslee Matthews - Flourish AUSTRALIA **Working Days: Monday – Friday**	P. 02 6766 1394
Armidale	Frances Prowse – HealthWISE **Working Days: Monday, Tuesday and Thursday**	P. 02 6771 1146
Armidale	Michael Bradley – HealthWISE **Working Days: Tuesday, Wednesday and Thursday**	P. 02 6771 1146