HealthWISE
Creating healthier communities

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.

- This form, once signed, 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 overall client focused outcomes.
- All information shared between the client and HealthWISE will be treated as strictly confidential, at all times.
- All data collected used for reporting purposes will be de-identified.
- You or your patient will notify HealthWISE if they are receiving any other assistance that supports your patient.
- 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:

click/tap to select

Date of Birth: / / **Gender:** ☐ Male ☐ Female ☐ prefer not to say

Address: (not PO Box) **Postcode**

Contact phone number:

Regular GP name:

Practice name:

Are you of Aboriginal descent? *click/tap to select* ☐ Yes ☐ No

Are you of Torres Strait Islander descent? *click/tap to select* ☐ Yes ☐ No

QIC ACCREDITED
ABN 48 603 486 442

213 Peel St
Tamworth 2340 NSW

HealthWISE
T: 02 6766 1394 **F**: 02 6766 1372
E: imh.staff@healthwise.org.au
W: healthwise.org.au

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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 (patient's name): _____ have read and understood the above Consent.

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.

Health professional's name: _____ Date: ___ / ___ / _____

Office use only

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 (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 Well Being Check - see next page

☐ Details of additional assistance needed i.e. Peer Navigation, Care Coordination, Group therapy support etc. Please fill in below *type details:*

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

Tamworth	**Amanda Naden** Working Days: Monday – Friday	**P. 02 6766 1394**
Armidale	**Frances Prowse** Working Days: Monday - Thursday	**P. 02 6771 1146**

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Social & Emotional Well Being Check - office use only

Reason for referral: *click/tap to select*

Suicide ideation/attempts ☐	**AOD misuse** ☐	**Mental Illness** ☐	**Mandated/Parole** ☐
Current, if yes ☐	Current ☐	Current ☐	
Intent ☐	History ☐	History ☐	
Plan ☐			
History ☐			

Self-harm/ Self-harm ideation ☐	**Family Violence** ☐	**Stolen Generation Issues** ☐
Current, if yes ☐	Current, if yes ☐	First Generation ☐
Intent ☐	Victim Survivor ☐	Second Generation ☐
Plan ☐	Perpetrator ☐	Third Generation ☐
History ☐	History ☐	Adoption/State Ward/ Fostered ☐

Nature of current issue/s: Significant issues/relevant information *Please type answer below*

Purpose of Referral: *click/tap to select*

MH Support ☐ AOD Support ☐ BTH Support ☐ Counselling ☐

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

Reason for risk level given: *Please type answer below*

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 member 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? ☐ N/A ☐ Yes ☐ No reason

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