SACRED HEART MISSION REFERRAL FORM

Date:		SHM Program:	

REFERRER'S DETAILS

Name:		Role:	
Agency:		Contact Details:	
Will your agency remain involved and if so in what capacity?			

PERSONAL DETAILS

Given Name:		Family Name:			
Gender:		Date of Birth:		Age:	
Address:					
Country of Birth:		Visa Status:			
Aboriginal or Torres Strait Islander:		Cultural ID:			
Preferred Language:		Interpreter Required: *Specify language*			
Phone Number:		Email:			
What is the best way to contact the client? *Do they listen to Voicemail messages, open and/or collect their mail? Are they able to read or do they need help with this?*					
Clients Primary income:		Centrelink Customer Reference Number (CRN):			

OTHER AGENCY OR PROFESSIONAL INVOLVEMENT

Worker Name	Agency	Role	Phone Number

CURRENT SITUATION

What areas in the person's life do they currently want support with?
What type of support do they want/need?

ANY KNOWN RISKS

☐	Health:	
☐	At-Risk Mental State or Mental Health Issue:	
☐	Alcohol and/or Other Drug:	
☐	History of Aggression and/or Violence:	
☐	Risk of Harm from Others:	
☐	Domestic and Family Violence:	
☐	Child Protection Issues:	

PERSONAL SAFETY

Are there any concerns regarding personal safety? *This can be to self, from others or due to unsafe housing/environment*	
Are they currently experiencing family violence or in danger or experiencing violence from anyone else?	

If "Yes" to either question above, please describe:

Is there a current IVO in place? If "Yes", please provide details:

Please provide details of current plan to address any safety concerns:

CLIENT PRESENTATION AND OTHER COMMENTS

Such as - presentation, level of insight into their situation, current readiness and capacity to engage with services, expectations of recovery, general mood, cognition and functioning.

CONSENT TO REFERRAL

I, ____ hereby give my consent for
(Client Name)

___________________________________ of ____
(Referring Worker) *(Referring Agency)*

to make a referral to ____ who will provide assistance related to
(Name of Service/Program)

____ .
(Support to be received)

I understand that acceptance for case management requires a commitment from me to meet regularly with my worker and actively work towards my goals.

Signed ____ Date__________

CONSENT TO OBTAIN AND EXCHANGE INFORMATION FORM

I, ____ hereby give my consent for Sacred Heart Mission:

to collect and share the following information about me:

- Additional information relevant to my referral for the purpose of assessing my suitability for case management.
- Information relevant to my support needs and service request.

with the below listed agencies or individuals:

(Please list all supports that you consent for SHM to contact, not just the referring agency)

____

____

____

____

I understand that in accordance with the Privacy and Data Protection Act 2014 (Vic), the Privacy Act 1988 (Commonwealth), the Health Records Act 2001(Vic) and the Charter of Human Rights and Responsibilities Act 2006 (Vic) that this information will be kept confidential and stored in a secure manner and that I can access this information by contacting the SHM Privacy Officer.

This consent is valid only to the items specified above and only for this referral.

I understand my right to withdraw my consent at any time.

Signed ____ Date__________

(or consent obtained verbally) Yes No (Reason if yes:)