**Registration forms can be forwarded to the West Vic PHN or**

**Ballarat/Maryborough and surrounds:** mentalhealthintake@bchc.org.au
**(PH)** 03 5338 4500

**Horsham/Stawell/Ararat and surrounds:** refer@gch.org.au
**(PH)** 03 5358 7400

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| **What Support can we supply?**  |
| We are a community-based program that will work with individuals to achieve their recovery goals such as: * Increase personal capacity, confidence, and self-reliance.
* Increase family and social connectedness.
* Maintain physical wellbeing, including exercise

Services included in the program includes:* Connecting2community - service co-designed by consumers, for consumers and delivered by peer workers.
* Individual sessions delivered by peer workers, mental health support workers and mental health clinician.
* Group based programs targeting a range of social needs.
* Service navigation
* DSP and NDIS application Support\*\*

The intensity of support provided to clients is flexible and based on client need.  |
| **Who is eligible?** |
| To be eligible clients must:* Not be receiving NDIS support
* Identify as having mental health difficulties
* Reside within the catchment area of the Grampians/Wimmera region of the Western Victoria Primary Health Network

**\*\*For NDIS applications a checklist must be completed prior to referral being made**  |

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| Referrer Details: |
| Referring Agency: |  | Date of Referral: | Click or tap to enter a date. |
| Worker’s name: |  | Workers Position: |  |
| Workers E-mail: |  | Workers PH: |  |
| Referral Details: |
| Name |  | Preferred name: |  |
| Date of Birth | Click or tap to enter a date. | Is this an estimate? | Choose an item. |
| Gender: |  | Identify as LGBTQI? | Choose an item. |
| Address |  |
| Post Code |  | Phone Number: |  |
| Email Address: |  | Preferred contact | Choose an item. |
| Country of Birth: |  | Indigenous Status: | Choose an item. |
| Main language spoken: |  | English Proficiency:  |  |
| Interpreter Required | Choose an item. | Health Care Card: | Choose an item. |
| Accommodation Type (e.g., private rental, public housing): |  |
| Employment Status: | Choose an item. | Source of income: |  |
| NDIS Participant? | Choose an item. | Marital Status: |  |
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| Emergency Contact name and phone number: |  |
| GP Clinic and GP Name: |  | Previous Mental Health Care? Choose an item. |
| Current Medications: Antipsychotics? Choose an item. Anxiolytics?Choose an item. Hypnotics? Choose an item. Antidepressants? Choose an item. Psychostimulants? Choose an item. |
| Reason for Referral: |
| E.g., increase community engagement, reduce isolation, NDIS / DSP application, etc. NOTE: NDIS /DSP applications must have completed checklist attached as part of referral.  |
| Does the individual have a recent history of suicide attempt, or suicide risk that underpinned the person’s need for assistance? Choose an item. |

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| **Consent**  |
| The client has consented to their personal information being collected/used/stored by Western Victoria Primary Health Network to assess eligibility, record and report on service delivery, evaluate programs and manage referrals.**If they say no:** If the client does not consent to sharing their personal information with WVPHN they cannot progress with the provider and program.[ ]  **Yes** [ ]  **No**By consenting to services under this program the client understands that the GP/(other referrer or health professional) is required to provide some information to WVPHN, the service provider and other health professionals involved in their care to ensure service best meets their needs [ ]  **Yes** [ ]  **No**The client has been made aware of who to contact to withdraw their consent or to discuss any privacy concerns[ ]  **Yes** [ ]  **No**The client consents to receiving experience surveys for their voluntary completion from either Western Victoria Primary Health Network or by an authorised third party. [ ]  **Yes** [ ]  **No**The client consents to participating in program evaluation, as well as being contacted for this purpose by Western Victoria Primary Health Network or by an authorised third party.[ ]  **Yes** [ ]  **No**As the funder of Psychosocial Support services and as authorised by Australian Privacy Principles, the Commonwealth Department of Health and Aged Care, state and territory health departments and evaluators need to know what kind of people are using the service and why, and for statistical and evaluation purposes designed to improve mental health services in Australia. **This includes the use of personal information to generate a unique key, which can be used to link my de-identified data to other deidentified data to facilitate research.** To support this, we need to tell the Department and third parties the Department engages how many people have contacted the service and we share generic de-identified details like your date of birth, gender, postcode and health outcomes. We will not share your name, address, Medicare number or other details that can be linked back to you. Is it ok to share your generic details?Option if they say No: You have noted that you do not consent to sharing your generic details. We inform you that in accordance with the Privacy Act and Australian Privacy Principles we will provide the Department with deidentified aggregated data. This includes data about your use of the services, combined with information about other clients in summary reports with no identifying features at an individual level. As these do not require personal information, consent is not required.[ ]  **Yes** [ ]  **No**To give you the best coordinated care, we try to work together with your other care providers such as your doctor or psychologist. We might need to contact an existing care provider to discuss your future care planning. In contacting an existing care provider, we will need to share your personal details. If you do not consent to us sharing your personal details with an existing care provider, we are unable to do so and will not be able to provide you with the most suitable service. Are you OK with us contacting an existing care provider to discuss your future care planning?[ ]  **Yes** [ ]  **No** |
| **Clinician Name confirming verbal or written consent has been provided as detailed above and placed on the client file:**  |