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| **C:\Users\michellemc\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\E1SMEKM9\Connecting2community logo.jpg** |

**Registration forms can be forwarded to the WestVicPHN**

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| EMAIL: refer@gch.org.auPHONE: 5358 7400 or 5338 4800 |

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| What is Community Mental Health Support?  |
| This is a clinical and non-clinical 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

The intensity of support provided to clients is flexible and based on client need.  |
| Who is eligible? |
| To be eligible clients must :* are not engaged with NDIS and having ongoing funding packages
* having ongoing mental health difficulties
* are over 18 years
* are not restricted in their participation in the community ( ie in prison or hospital)
* within the catchment area of primary health network
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| Referral details |

Name: Click here to enter text. Preferred Name/s: Click here to enter text.

Date of birth: Click here to enter text. Is this an estimated date? [ ]  Yes [ ]  No

Gender: [ ]  Male [ ]  Female [ ]  Intersex or Indeterminate [ ]  Other

Address: Click here to enter text. Post Code: Click here to enter text.

Telephone: Click here to enter text. Mobile: Click here to enter text.

GP: Click here to enter text.

Emergency Contact (Name/Relationship/Number): Click here to enter text.

Referring Agency: Date of referral:

Worker’s name: Telephone:

Email: Click here to enter text. Fax: Click here to enter text.

Identifies as LGBTQI? Yes [ ]  No [ ]

Country of birth: Indigenous status: Not stated/inadequately described

Main Language spoken: English proficiency: Choose an item.

Interpreter required? Yes [ ]  No [ ]

Homelessness: Work status

Employment status: N/A Source of cash income:

Health care card: Yes [ ]  No [ ]  NDIS participant: Yes [ ]  No [ ]

Marital status: Not stated/inadequately described

**Principal diagnosis**:

**Additional diagnosis:** Click here to enter text.

Does the individual have a recent history of suicide attempt, or suicide risk that underpinned the person’s need for assistance? Yes [ ]  No [ ]

Prior mental health care? Yes  [ ]  No [ ]

Is patient on Antipsychotics? Yes [ ]  No [ ]

Is patient on Anxiolytics? Yes [ ]  No [ ]

Is patient on Hypnotics? Yes [ ]  No [ ]

Is patient on Antidepressants? Yes [ ]  No [ ]

Is patient on Psychostimulants? Yes [ ]  No [ ]

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| Consent |

I consent to my information being provided by Western Victoria Primary Mental Health Network to the Department of Health for statistical and evaluation purposes designed to improve mental health services In Australia. I understand that this will include details about me such as date of birth, gender and types of services I use but will not include my name, address or Medicare number. I understand that my information will not be provided to the Department of Health if I do not give my consent.

I give my consent: Yes [ ]  No [ ]

*By consenting to the services under this program the client understands that the referrer is required to provide some information to WVPHN and health professionals involved in their care to ensure service best meets their care.*

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.

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 the Your Experience of Service (YES) Survey 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 [ ]

Client signature:

Date of Consent:

Further information: