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| --- | --- |
| Referrer Name: | Profession: |
| Facility Name: | Facility No: |
| Client Information |
| Client Name: | Direct Client Phone No: |
| Address: |
| City: | State: | Postcode: |
| DOB: | Gender [ ]  Male [ ]  Female |
| Country of Birth: | Interpreter Required [ ]  Yes [ ]  No |
| Aboriginal and/or Torres Strait Islander [ ]  Yes [ ]  No | Facility Date of Entry: |
| Legal Standing/Rights [ ]  PoA [ ]  Enduring PoA [ ]  Guardian [ ]  Person ResponsibleName: Contact No: |
| Reason for Referring: |
| Mental Health Issues: |
| Physical Health Issues: |
| Relevant Diagnoses: |
| History of Violence [ ]  Yes [ ]  No |
| Psychogeriatric Assessment Scale Score (PAS):  | Delirium Excluded (CAM) [ ]  Yes [ ]  No |
| ***I confirm and understand:**** *I have been informed of the role and services provided by the Anglicare Emotional Wellbeing for older persons support programme*
* *I understand that the information provided in this referral is required to determine my eligibility for services.*
* *I give my consent for services to be provided by suitable programs, as agreed to by me.*
* *I give permission for the exchange of this information between my care team, GP and other agencies for the purpose of coordination of care.*
* *I consent to my de-identified information to be used for statistical purposes by Anglicare, Sydney North Primary Health Network and NSW Department of Health.*
* *I understand that my personal information will be collected in accordance with Privacy legislation and the management and storage of my information has been described to me within this form;*
* *I understand and consent to Anglicare staff providing services for the Emotional Wellbeing for Older Persons Support Programme from home.*
 | Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referrer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referrer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  As a Referrer, I confirm that I have explained the information to the referred client, and I have witnessed their signature. |
| ***Please return the completed form to: mhracs@anglicare.org.au*** |

**COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION**

Anglicare is committed to managing all personal information in a manner that reflects its legal responsibilities under the Health Records and information privacy and personal information protection regulation 2014 (NSW) and the Privacy Act 1988 (Commonwealth).

We collect personal information prior to and during the time you spend in this programme. The primary purpose of this is to plan, deliver and review the effectiveness of the support we provide. Other Health professionals or services, who provide care to you, may request access to your personal information.

Collection of personal information is limited to that which is necessary to operate efficiently, effectively and in line with statutory requirements. Personal information that we may collect about you includes:

* Your name and date of birth
* Your health and medical details
* Details of your social situation
* Cultural details

We have systems in place to protect your information from loss, alteration, improper use, inappropriate access and disclosure. If you have any concerns about disclosing personal information, you should speak to the Anglicare staff member.

Your decision to withhold required personal information may affect Anglicares ability to provide you with care and services. To view any information kept about you, please speak to an Anglicare staff member in the first instance, all requests to view personal information will be referred to Anglicares privacy officer.