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| The EWOPI program supports people over 65 (or over 55 if Aboriginal/ Torres Strait islander) who are at risk of, or have, mental health issues and are experiencing social isolation or loneliness as a consequence of the COVID-19 pandemic.  Intended Outcomes:   * Connection to services and support * Reconnecting with social networks * Restoring access to disrupted services * Early intervention and psychological support * Referrals to other appropriate services * Provision of information to clients as well as their families, friends and carers   Eligibility: Clients who reside in the Local Government Areas (LGAs) of Hornsby, Hunters Hill, Ku-ring-gai, Lane Cove, Mosman, North Sydney, Northern Beaches, Ryde and Willoughby. | | | |
| Referrer Name: | Profession: | | |
| Relationship to client: | Contact details: | | |
| Client Information | | | |
| Client Name: | Direct Client Phone No: | | |
| Address: | | | |
| Suburb: | State: NSW | | Postcode: |
| DOB: | Gender  Male  Female  Other | | |
| Country of Birth: | Interpreter Required  Yes  No | | |
| Aboriginal and/or Torres Strait Islander  Yes  No | Identified cultural values, beliefs, traditions, and customs: | | |
| Person being referred is responsible for their own legal standing/ rights  or has the following  Power of Attorney  Enduring PoA  Guardian  Name: Contact Details: | | | |
| Reason for referring: | | | |
| Mental health issues/ diagnoses: | | | |
| Physical health Issues/ diagnoses: | | | |
| Details of identified risk issues including known risks to home visiting staff: | | | |
| Risk management plan/ strategies to mitigate risks: | | | |
| Relevant information / reports provided with this referral:  1.  2.  3. | | | |
| GP Name and contact details | | | |
| Name:  Phone:  Email: | | | |
| **Consent**  **I confirm and understand:**   * I have been informed of the role and services provided by the Anglicare Emotional Wellbeing for Older Persons In-reach program * I understand that the information provided in this referral is required to determine my eligibility for services. * I give my consent for referral to suitable services and programs, as agreed to by me. * I give consent 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 Health Network and the Department of Health. * I understand that my personal information will be collected in accordance with privacy legislation. * I consent to Anglicare staff providing me Emotional Wellbeing for Older Persons In-reach services. | | **Client Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Referrer Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Referrer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  As a Referrer, I confirm that I have explained the information on this form to the referred client, and I have **witnessed** their signature.  Or  As a Referrer, I confirm that I have explained the information on this form to the referred client and obtained **verbal consent** during a phone call at (time) \_\_\_:\_\_\_am/pm on (date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. | |
| ***Please return the completed form to Emma Wilson:*** [***AEWOPI@anglicare.org.au***](mailto:AEWOPI@anglicare.org.au) ***For further information, call Emma on 0403 396 697*** | | | |

**The Anglicare Emotional Wellbeing for Older Persons In-Reach program is supported by funding from the Australian Government through the PHN Program**

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| **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 program. 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 Anglicare’s 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 Anglicare’s privacy officer. |