|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Participant Details** | | | | | | | | | | | | | | | | | | | | | |
| Full Name | | | |  | | | | | | | | | | Preferred Name | | | |  | | | |
| Date of Birth | | | |  | | | Gender | | | | Male  Female  Non-Binary  Other | | | | | | Preferred Pronouns: | | | |  |
| Email | |  | | | | | | | | | | | | | Contact No. | | | | |  | |
| Address | |  | | | | |  | | | | | | | | | | | | | | |
| Country of Birth | | | | |  | | | | | | | | Main Language at Home | | | | | |  | | |
| Origin Status | | | | | | Aboriginal  Torres Strait Islander  Both  Non-Indigenous  Unknown  Not stated | | | | | | | | | | | | | | | |
|  | | | | | |  | | | | | | | | | | | | | | | |
| **Emergency Contact** | | | | | | | | | | | | | | | | | | | | | |
| Full Name | | | | | |  | | | | | | | | Contact No. | | | | |  | | |
| When do you consent for us to call your emergency contact (tick all that apply) | | | | | | | | | | | | | | | | | | | | | |
| If I do not answer my scheduled call | | | | | | | | | | If emergency services or the NT Mental Health Crisis Team was called | | | | | | | | | | | |
| Other (please describe): | | | | | | | | | |  | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Current mental health concerns and/or diagnosis** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Preferred scheduled calls (day/s of week, time of day, frequency)** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Are you a current or past participant of another TeamHEALTH program?** | | | | | | | | | | | | | | | | | | | | | |
| Yes (please specify:) | | | | | | | |  | No | | | If ‘YES’ do you have a current safety plan? | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | |  | | |
| **Referrer Details** | | | | | | | | | | | | | | | | | | | | | |
| Full Name | | |  | | | | | | | | | | | | Contact No**.** | | | |  | | |
| Referring Organisation/Agency *(if applicable)* | | | | | | | |  | | | | | Relationship to Participant | | | | | |  | | |
| Email |  | | | | | | | | | | | | | | | Signature | | |  | | |
|  | | | | | |  | | | | | | | | | |  | | |  | | |
| **Consent** | | | | | | | | | | | | | | | | | | | | | |

I consent to this referral. I understand that this 31information will be stored on the TeamHEALTH system and may be used for reporting and audit purposes. I understand and consent that as part of reporting obligations TeamHEALTH may be required to share de-identified information with relevant funding bodies. I understand the TeamHEALTH Privacy Statement can be viewed and accessed at ***https://www.teamhealth.asn.au/privacy*** or I can request a copy from TeamHEALTH.

I consent to a TeamTALK Coach to contact me on the above stated days and times and I understand that my emergency contact will be contacted as per my selections above. Any of the above stated details and/or consents can be withdrawn or adjusted at any time by the participant and/or guardian.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Signature of Participant |  | Signature of Parent/ Guardian (if applicable) | |  | Date |
| **In the absence of written consent, verbal consent was gained** | | | Yes | No | |

|  |  |  |
| --- | --- | --- |
| Participant risk factors (if selecting yes to any of the below please expand on or attach relevant information/documentation) | Yes | No |
| History of suicide attempt/s or current suicide ideation |  |  |
| Recent traumatic life event |  |  |
| Current misuse of drugs or alcohol |  |  |
| Forensic history |  |  |
| Recent incident involving aggression/violence |  |  |
| Known use of weapons |  |  |
| Expressing intent to harm others |  |  |
| Expressing intent to harm others |  |  |
| Preoccupation/hallucinations with violent or paranoid themes/ideas |  |  |
| Inappropriate sexual behaviour |  |  |
| Reduced ability to self-control / self-regulate |  |  |
| Major physical disability/illness (including infectious disease) |  |  |
| Known prejudices – ethnic, religions, other: |  |  |
| Issues with compliance eg appointments, medication. If yes, please detail: |  |  |
| Protective Factors | | |
| Other Identified Risks | | |

|  |
| --- |
| **Completing this form** |

* Please call TeamHEALTH on 1300 780 081 if you need any assistance completing this form.
* Send the completed form to: [teamtalk@teamhealth.asn.au](mailto:teamtalk@teamhealth.asn.au)
* TeamHEALTH will contact the referrer within two working days of receiving this form.

Thank you for your referral