|  |
| --- |
| **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 [x]  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 Any of the above stated details and/or consents can be withdrawn or adjusted at any time by the participant and/or guardian.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
* TeamHEALTH will contact the referrer within two working days of receiving this form.

Thank you for your referral