TeamTALK Referral and Consent Form

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 information 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

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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 Any of the above stated details and/or consents can be withdrawn or adjusted at any time by the participant and/or guardian.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		

Participant risk factors (if selecting yes to any of the below please expand on or attach relevant information/documentation)	**Yes**	**No**
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

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