DATE:

CHIPS REFERRAL FORM

***All referrals are to be faxed to the CHIPS Coordinator: (02)60245792**

Personal Details

Client ID: _____

Given Name: _____

Preferred Name: _____

Family Name: _____

Date of Birth: _____

Gender: Male Female Intersex/Indeterminate Not stated/Inadequately described Other

Verbal Consent

I give consent for a referral to be sent through to the CHIPS program Yes/No

I give consent for my personal information to be used in a way that is de-identified (e.g. name, address is not used) Yes/No

Consent for future contact for survey/research/evaluation. Yes/No

Do you require a support person? Yes/No

Residential Address

Address: _____

Suburb/Town: _____

State: _____

Postcode: _____

Phone: _____

Demographic Details

Country of Birth: _____

Main Language spoken at Home: _____

Is there a need for interpreter services? _____

Is the client of Aboriginal or Torres Strait Islander origin? _____

Refugee Status: Yes/No/Not Stated

If yes, year of arrival: _____

Does the client have one or more of the following impairments, conditions or disabilities?

Intellectual learning Yes/No

Psychiatric Yes/No

Sensory/speech Yes/No

Physical/diverse Yes/No

Not stated/inadequately described Yes/No

None

Contacts

Parent or Significant other:

Name: _____

Address: _____

Phone: _____

Relationship to consumer: _____

Date of Birth:_____

Willing to participate: Yes/No

Parent or Significant Other:

Name: _____

Address: _____

Phone: _____

Relationship to consumer: _____

Date of Birth:_____

Willing to participate: Yes/No

Emergency Contact:

Name: _____

Address: _____

Phone: _____

Relationship to consumer: _____

Financial

Source of Income: _____

Health Care Card: _____

Are there any custody arrangements for your child that may impact upon their participation in the CHIPS program or any Child Protection Orders? Yes/No

Please Specify: _____

Person Completing Form/Referrer

Date: _____

Name: _____

Role: _____

Organisation: _____

Phone: _____

Fax: _____

Children

Child's Name:	Child's Name:
DOB:	DOB:
Gender:	Gender:
Address:	Address:
Child's Name:	Child's Name:
DOB:	DOB:
Gender:	Gender:
Address:	Address:
Child's Name:	Child's Name:
DOB:	DOB:
Gender:	Gender:
Address:	Address:

Current Support/Services

Reason for Referral

Consent to share information

Purpose: to record freely given informed consumer consent to share their information with a specific agency/ies for a specific purpose/s.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Section 1: Personal/health information to be shared

Service Type Examples: – physiotherapy – counselling	**Name of Agency** Examples: – Strawberry Community Health centre – Blueberry City Council	**Type of Information** Examples: – all relevant information – exceptions as stated by consumer	**Purpose/s** Examples: – referral – shared care/case planning -- informing services participating in consumer's care

Section 2: Record of consent

☐ **Written consumer consent**

The worker/practitioner has discussed with me how and why certain information about me may be shared with other service providers, as above. I understand this and I give my consent for the information to be shared.

Signed:_____

Dated (dd/mm/yyyy): / /

or

☐ **Verbal consumer consent**

I have discussed with the consumer how and why certain information may be shared with other service providers. I am satisfied that this has been understood and that informed consent for the information to be shared as detailed above has been given.

or

☐ **Consumer does not have the capacity to provide consent**

(that is, they do not understand the nature of what they are consenting to, or the consequences)

☐ Consent given by authorised representative _____

(name of authorised representative)

☐ There is no Authorising representative or they were uncontactable; therefore, the information will be shared as set out in the *Health Records Act 2001**

*If it is not reasonably practical to obtain consent from an authorised representative or the consumer does not have an authorised representative, health information can still be shared in the circumstances set out in the *Health Records Act 2001*. This includes where the sharing of information is done by a health service provider and is reasonably necessary for the provision of a health service or where there is a statutory requirement.

To ensure that the consumer's authorised representative can make an informed decision about consenting to the sharing of information as detailed above, the worker/practitioner should (tick when completed):

1. Discuss with the consumer the proposed sharing of information with other services/agencies ☐
2. Explain that the consumer's information will only be shared with these services/agencies if the consumer has agreed and, when referring, advise that referral for service can still proceed if the consumer does not want information disclosed ☐
3. Provide the consumer with information about privacy, such as the brochure *Your Information – It's Private* ☐
4. Provide the consumer with a copy of this form once completed. ☐

Produced by the Victorian Department of Health, 2012

Consent obtained/witnessed by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Consent to Share Information

January 2016