Hearing Voices Mental Health Support Group Referral

TeamHEALTH actively promotes and supports an inclusive and diverse culture. We welcome all people, regardless of age, gender, race, ability, sexual orientation, faith, religion and all other identities represented in our community.

What is the Hearing Voices Group

TeamHEALTH's Hearing Voices Group is for people with shared experiences who come together to support one another. The group offers a safe space where people who hear, see or sense things that other people don't, can feel accepted, valued and understood.

Date of Referral ______________________________

Participant Details

Participant's Name ______________________ Preferred Name ______________

Date of Birth ______________________ Gender ______________

Email Address ______________________ Phone Number ______________

Address ____

Emergency contact details ____

Country of Birth ______________________ Language at Home ______________

Origin ☐ Aboriginal ☐ Torres Strait Islander ☐ Non-Indigenous ☐ Not Stated

Community (if applicable) ______________________

Interpreter Required? ☐ No ☐ Yes

Referral Details

Reasons for wanting to be part of the Hearing Voices Community Group

Person Referring ____

Relationship to Participant ____

Contact Details ____

Referrer's Signature ______________________________ Date ______________

Person consenting to group referral ☐ Yes ☐ No

Consent

TeamHEALTH uses personal information to assist in the coordination and provision of services. Individuals are not required by law to provide this information or consent to this proposed use and disclosure of information.

The information provided to TeamHEALTH will be stored in accordance with the Australian Privacy Principles established under the Privacy Act 1998 (Commonwealth) and Northern Territory of Australia Information Act.

Signature of Participant	Signature of Public Guardian (if applicable)	Date

In the absence of written consent, verbal consent was gained ☐ No ☐ Yes

Light refreshments will be provided. Please let us know if you have any dietary requirements and/ or food allergies.

Risk Assessment (Referrer to complete)

Risks identified	Yes	No	Low	Medium	High
Self-harm	☐	☐	☐	☐	☐
Suicide (thoughts, plans, attempts)	☐	☐	☐	☐	☐
Violence/aggression	☐	☐	☐	☐	☐
Abuse/trauma	☐	☐	☐	☐	☐
Substance use	☐	☐	☐	☐	☐

Diagnosis

☐ No ☐ Yes, details: ____

____

Current Medications

☐ No ☐ Yes, List: ____

____

Other identified risks

Does the person have a safety plan? If so, please attach with referral

Protective factors

Completing this Form

- Please call TeamHEALTH on 1300 780 081 if you need any assistance completing this form.
- Send the completed form to: AdultSupportsReferrals@teamhealth.asn.au
- We will respond to referrals within 24 hours or next business day to arrange an assessment.

Thank you for your referral