Lifeline
Macarthur and Western Sydney

SUICIDE AFTERCARE PROGRAM REFERRAL (page 1 of 2)

PERSONAL DETAILS OF PERSON TO BE REFERRED		
Date:	**Date of Birth:**	
Surname:	**Given Name:**	**Title:**
Address:	**Suburb:**	
Phone:	**Email:**	
Gender:	**Country of Birth:**	
Identify as CALD ☐ Yes ☐ No	**Main Language Spoken at Home:**	
	Is a Language Interpreter required? ☐ Yes ☐ No	
Employment Status:		
☐ Full-time	**Indigenous Status:**	
☐ Part-time/Casual	☐ Aboriginal	
☐ Not Employed	☐ Aboriginal & Torres Strait Islander	
☐ Retired	☐ Torres Strait Islander	
☐ Student	☐ Not Aboriginal or Torres Strait Islander	
☐ Not Stated	☐ Not Stated	
Mental health diagnosis: ☐ **None**	☐ **Yes, please state below:**	

Please list current, if any, medications:	Does the referred have Private health insurance?
	☐ No
	☐ Yes

CONTACT DETAILS OF PERSON MAKING THE REFERRAL	
Full Name:	Position:
Organisation:	
Suburb:	Postcode:
Phone:	Mobile:
Email:	
Please attach a copy of the most current K10 or K10+ Score:	
Signature:	

SUICIDE AFTERCARE PROGRAM REFERRAL (page 2 of 2)	
TREATING MENTAL HEALTH PROFESSIONAL If different to person making referral	
Full Name:	Position:
Organisation:	
Suburb:	Postcode:
Phone:	Mobile:
Email:	

CONSENT

Referrers must confirm that they have read out the following information to the client and they understand and have given (informed) consent or verbal consent:

- to receive telephone support from Lifeline
- to Lifeline providing feedback to referee and treating Mental Health Professional
- to Lifeline contacting emergency services if life is at imminent risk
- to Lifeline contacting emergency contact in cases of increased safety risk
- to your information being shared between the service provider and the funding body South Western Sydney PHN (SWSPHN), in accordance with the Privacy Act 1988
- to being contacted by the service provider or SWSPHN to complete a client experience of service survey

Signature: Or ☐ Verbal Consent

CONSENT FOR LIFELINE TO LEAVE A MESSAGE (If person is unable to be contacted) (Tick that apply)

☐ Voice mail ☐ Text ☐ Email

EMERGENCY CONTACT	
Name:	Phone:
Relationship to person being referred:	

Please send Referral to: suicideprevention@lifelinemacarthur.org.au

To discuss this referral contact:

Suicide Prevention Team Leader
Ph: 8923 4819
Email: suicideprevention@lifelinemacarthur.org.au

OFFICE USE ONLY:

DATE REFERRAL RECEIVED: *RECEIVED BY:*