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:** _____ **Postcode:**_____

Phone: _____ **Email:**_____

Gender: ☐ Male ☐ Female ☐ Other

Country of Birth:

Identify as CALD: ☐ Yes ☐ No

Main Language Spoken at Home:

Employment Status:
- ☐ Full-time
- ☐ Part-time/Casual
- ☐ Not Employed
- ☐ Retired
- ☐ Student
- ☐ Not Stated

Is a Language Interpreter required?
☐ YES ☐ NO

Indigenous Status:
- ☐ Aboriginal
- ☐ Aboriginal & Torres Strait Islander
- ☐ Torres Strait Islander
- ☐ Not Aboriginal or Torres Strait Islander
- ☐ Not Stated

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: _____

TREATING MENTAL HEALTH PROFESSIONAL if different to person making referral

Full Name: _____**Position:**_____

Organisation:_____

Suburb:_____ **Postcode:**_____

Phone: _____ **Mobile:**_____**Email:**_____

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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 all that apply)

☐ Voice mail ☐ Text ☐ Email

EMERGENCY CONTACT:

Name: _____ **Phone:** _____

Relationship to person being referred: _____

Please send Referral to: Fax: **4645 7250** Email: suicideprevention@lifelinemacarthur.org.au

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To discuss this referral contact: Suicide Prevention Team Leader on-

Ph: **4645 7212**

Email: suicideprevention@lifelinemacarthur.org.au

OFFICE USE ONLY:

DATE REFERRAL RECEIVED: RECEIVED BY: