gateway health
People living well

CHIPS
Child Health Intervention and Parent Support

REFERRAL DATE:
CLIENT ID: (office use):

All referrals are confidential and can be emailed to intake.chips@gatewayhealth.org.au or contact the coordinator on 0438567247.

Personal Details

Given Name: (Child) Preferred Name:

Family Name:

Date of Birth:

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

Verbal Consent: Services and schools, please complete with adult of child referred.

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) to record service. Yes/No

Consent for future contact to evaluate the service. Yes/No

Do you require a support person? Yes/No

Residential Address

Address:

Suburb/Town:

State: Postcode:

Phone: School/Preschool:

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? No

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: **E-Mail :**

Relationship to child:

Date of Birth:

Willing to participate: Yes/No

Parent or Significant Other:

Name: _____

Address: _____

Phone: _____

Relationship to child: _____

Date of Birth:_____

Willing to participate: Yes/No

Emergency Contact:

Name:

Address:

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:

Email:

Other 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/people

Reason for Referral i.e. challenges, concerns, events?

What is going well? strengths?

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.

Consent to Share Information

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: