**Wesley Lifeforce Aftercare Service Referral form**

The Pilot Suicide Aftercare Service in Coffs Harbour will assess people into the program based on the following criteria:

Is a person:

1. Who has recently attempted suicide or at risk of suicide (such as self-harm behaviours or suicide ideation)
2. The individual will have suicidal thoughts that they may act on
3. Who is not being support by another Suicide Aftercare Service
4. The person is 18 years of age or above
5. The person resides in the Coffs Harbour LGA.

|  |
| --- |
| Referral provider details |
| Name |  |
| Position and workplace |  |
| Phone number |  |
| Email |  |

|  |
| --- |
| **Client details** |
| **Last Name** |   | **Given name** |   |
| **Other names** |   | **Gender** [ ]  M [ ]  F [ ]  TR  [ ]  IN [ ]  Prefer not to say | **Date of birth**\_ \_ / \_ \_ / \_ \_ \_ \_ |
| **Preferred Pronoun** |  [ ] He/Him [ ] She/Her[ ] They/Them [ ] Other | **Other Pronoun** |  |
| **Address** |   | **Suburb** | **Postcode****\_ \_ \_ \_** |
| **Phone (Home)** |   | **Phone (Mobile)** |   |
| **Email** |   |
| **Next of Kin (relationship, contact details)** |  |
| **Preferred contact**  | [ ] Client [ ]  Support Person \_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_ (Please only tick Support Person if they are to be contacted before the client)[ ] Mobile phone [ ]  Home phone [ ]  Email [ ]  Other [ ] Anytime from 9 am to 5 pm [ ]  After 9 am [ ]  After 12 mid-day[ ] Other  |

**Aboriginal and/or Torres Strait Islander origin?**

[ ]  Aboriginal [ ]  Torres Strait Islander [ ]  Both [ ]  Neither

**Cultural background they would like noted?**

[ ]  Yes ­­­­­………………………………………………[ ]  No

**Is an interpreter required?** [ ]  Yes [ ]  No

***If yes, what language?***...................................................................

**Is there a disability, impairment or long-term condition?**

[ ] Yes [ ]  No

***If yes, please select the appropriate area(s)***

[ ] Hearing

[ ] Acquired brain impairment

[ ] Physical

[ ] Vision

[ ] Intellectual

[ ] Medical condition

[ ] Mental Health

[ ] Other

 ……………………..

**Does the client consider themselves neurodivergent?** [ ]  ASD [ ]  ADHD [ ]  Other [ ]  No

**What is the reason/s for referral?**

**……………………………………………………………………………………………………………..**

**Has there been a recent suicide attempt?**

[ ]  **Yes** [ ]  **No**

***If yes, what is the client’s history of suicide attempt? (please include dates and number of attempts)***

**........................................................................................................................................................**

**Is there a risk of suicide (such a self-harm behaviours or thinking about suicide)?**

**........................................................................................................................................................**

**Does the client face any of the following challenges?**

[ ] Previous suicide attempt/s

[ ] Bereaved by suicide

[ ] Bullying

[ ] Peer pressure

[ ] Drug and alcohol use

[ ] Relationship issues

[ ] Parent/child conflict

[ ] Unemployment

[ ] Financial stress

[ ] Loss of responsibilities

[ ] Substance abuse

[ ] Relationship breakdown

[ ] Lack of time with children

[ ] Work pressures

[ ] Family commitments

[ ] Chronic illness

[ ] Grief and loss

[ ] Immobility

[ ] Isolation

[ ] Changes in circumstances beyond your control

[ ] Changing pace of society and technology

[ ] Feeling like a burden

**Who are the people and supports around this person?**

**........................................................................................................................................................**

**........................................................................................................................................................**

**Are they being supported by any other Aftercare service or other service?**

**........................................................................................................................................................**

**What safety measures have been put in place between leaving the provider today and this referral being actioned? (referral to be actioned by Wesley Mission Aftercare Coordinator within 48hrs)**

**………………………………………………………………………………………………………….............................................................................................................................................................................**

**Privacy and personal information**

Your personal information is protected by law (including the Privacy Act 1988) and is being collected by or for Wesley Mission to allow us to contact you further to discuss the Aftercare program. Your information will only be provided to other parties; that you have agreed to; or where it is required or authorised by law.

**Participant declaration**

I certify that the personal information provided in this application form is correct. I give permission for information and records about me to be collected by Wesley Lifeforce Aftercare, which will be kept in a secure location for the purpose of providing ongoing care. This information will also be used to collect data on the use of the Aftercare program which will not identify you.

I give consent to be in the Aftercare program.

**Client Name** ……………………………………………….

**Signature** ………………………………………………. **Date** …………………………….

**Please return completed and signed form to the email address mentioned below.**

Wesley Mission Aftercare Service

Email: aftercare@wesleymission.org.au

Call: 02 5646 5718

71 Albany Street Coffs Harbour NSW

ABN 42 164 655 145

Wesley Mission’s Aftercare Coordinator will contact the client within 48 hours on receipt of this referral.