First Nations Liaison Officer Referral Form

Latrobe Community Health Service

Method of referral:

☐ Internal referral ☐ External referral *(if so, please complete details below).*

Organisation:	Date:
Name of referee:	Phone:
Email address:	Fax:

Eligibility Criteria

Does the client identify as First Nations?

☐ Yes ☐ No (ineligible)

Does the client live in the Gippsland region?

☐ Yes ☐ No (ineligible)

If this referral does not meet the above eligibility criteria the referral will not be considered.

Details of the client	
Name:	
Preferred name:	Pronoun (She/her He/him They/them):
Address:	
Age:	Contact number (s)
Date of birth:	Email:
Gender:	Who is your mob?:

Presenting issues and relevant details

Please provide as much detail as possible so we can prioritise as needed.

Please note- the First Nations Liaison Officer may be able to assist with the following;

- Provide clients with cultural and social support
- Attend appointments at LCHS or partnering organisations to assist clients to understand health information
- Advocate for clients and ensure staff understand cultural needs
- Provide support to client's family
- Provide advice on cultural appropriateness of care plans
- Connect and assist with referrals to other services in the community
- Act as a mediator in disputes or misunderstandings between First Nations clients and LCHS staff or other organisations
- Support discharge planning and processes

Relevant details:

Continued over

Relevant details *continued*:

Consent to referral

☐ Written Consent

I consent to the above information being shared with Latrobe Community Health Service in order to process my referral to the First Nations Liaison Officer.

Signed: _____ Date: _____

Name: _____

☐ Verbal Consent

I have discussed this referral with the client and they have provided verbal consent to share their information.

Signed: _____ Date: _____

Name: _____

Please email completed referral form to LCHS Service Access Team on ServiceAccessInbox@lchs.com.au