

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

☐ Yes ☐ No (ineligible)

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

- 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*:**Representative details**

Please complete this section if you are an authorised representative and are completing this form on behalf of an LCHS client / patient where:

- The client / patient is under 18 years and you are a representative, or
- You are a legally appointed decision maker for the client / patient. (*Please attach evidence*)

Full name

Date of birth

Address

Postcode

Contact phone

Contact email

Relationship to client / participant

Legal authorisation type (eg. medical decision maker, power of attorney)

Where consent is provided by an authorised representative

- I confirm I hold legal authorisation to represent the client listed on this form.

Signed by authorised representative

Name

Date

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: