Bunjilwarra

**Koori Youth Alcohol and Drug Healing Service**

**Expression of Interest**

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| --- | --- | --- | --- |
| **Date:** |  | **Referrer name:** |  |
| **First Name:** |  | **Surname:** |  |
| **Date of Birth:** |  | **Age:** |  |
| **Birth accuracy:**  | **Accurate / Estimate** | **Gender:** | **M / F / Other** |
| **LGBTIQ status:** |  **Yes / No** | **If yes, how do you identify:** |  |
| **Contact Address:** |  | **P/Code** |  |
| **Contact Phone:** |  | **Mobile:** |  |
| **Country of Birth:** |  | **Cultural/Linguistic****Background:** |  |
| **Aboriginal:** |  **Yes / No** | **Language Spoken:** |  |
| **Torres Strait Islander:** |  **Yes / No** |
| **Medicare No.:**  |  | **Expiry Date:** |  **/ /** |
| **Healthcare Card Number:** |  | **Expiry Date:** |  **/ /** |
| **Current Source of Income:** |  |
| **If Centrelink, what type of payment:** |  |
| **WORKERS (e.g. AOD, mental health, juvenile justice, outreach, Aboriginal Co-ops etc)** |
| **Do you currently have any workers assisting you?**  |  **Yes / No** |
| **If yes, please list details below:** |
| **Name** | **Organisation** | **Work Capacity****(how are you working with the young person)** | **Contact Details****(phone/fax/email)** |
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| **FAMILY** |
| **Mother’s Name:** |  |
| **Contact Address:** |  | **P/Code** |  |
| **Contact Phone:** |  | **Mobile:** |  |
| **Does your mother speak English:** |  **Yes / No** | **If no, then what****language is spoken** |  |
| **Type of contact with mother:** | **please circle:** | **no contact** | **infrequent** | **regular** |
| **Father’s Name:** |  |
| **Contact Address:** |  | **P/Code** |  |
| **Contact Phone:** |  | **Mobile:** |  |
| **Does your father speak English:** |  **Yes / No** | **If no, then what****language is spoken** |  |
| **Type of contact with father:** | **please circle:** | **no contact** | **infrequent** | **regular** |
| **If you are under 18 years of age, who is your legal guardian? Please provide details below:** |
| **❑ mother only** | **❑ father only** | **❑ both mother and father** | **❑ other (provide details below)** |
| **Name/s:** |  |
| **Contact Details:** |  | **Relationship to you:** |  |
| **STEP – PARENTS (if other than above)** |
| **Name/s:** |  |
| **Contact Details:** |  |
| **SIBLINGS – Do you have any brothers or sisters? If yes, please complete details below:** |
| **Name/s:** |  | **Ages:** |  |
| **PARTNER** |
| **Name/s:** |  |
| **Contact Details:** |  |
| **CHILDREN – Do you have any children? If yes, please complete details below:** |
| **Name/s:** |  | **Ages:** |  |
| **Who do they live with:** |  | **Custody Arrangements:** |  |
| **NEXT OF KIN – Who should we contact in case of an emergency?** |
| **Name/s:** |  |
| **Contact Details:** |  | **Relationship to you:** |  |
| **OTHER SIGNIFICANT RELATIONSHIPS** |
| **Name/s:** |  |
| **Contact Details:** |  | **Relationship to you:** |  |
| **SUBSTANCE USE HISTORY** |
| **What do you believe is the substance that has caused you the most problems:** |  |
| **In the past four weeks (28 days) have you used any of the following substances (including alcohol & tobacco)** |
| ***Substance*** | ***Yes*** | ***No*** | ***Method of use (e.g. smoked, inhaled, ingested, I.V. etc)*** |
| **Alcohol (Goon, Mossi)** |  |  |  |
| **Cannabis (Yarndi)** |  |  |  |
| **Methamphetamines (Ice)** |  |  |  |
| **Other amphetamines (e.g. speed, ecstasy)** |  |  |  |
| **Prescribed sedatives or sleeping pills (e.g. benzodiazepine, Xanax, valium, serapax etc)** |  |  |  |
| **Non-prescribed benzodiazepines** |  |  |  |
| **Prescribed Opioids (e.g. suboxone, methadone)** |  |  |  |
| **Non-prescribed Opioids (e.g. heroin, codeine, methadone, oxycodone, morphine etc.)** |  |  |  |
| **Cocaine** |  |  |  |
| **Inhalants (e.g. nitrous, glue, petrol, paint etc.)** |  |  |  |
| **Hallucinogens (eg.g LSD, acid, mushrooms, PCP, ketamine, synthetics etc.)** |  |  |  |
| **GHB** |  |  |  |
| **Tobacco** |  |  |  |
| **Other substances (e.g. steroids, synthetic cannabis, other new and emerging drugs etc.)** |  |  |  |
| **Have you injected drugs in the past four weeks?** |
| **Have you injected drugs in the past four weeks** |  **Yes / No** |
| **If yes did you inject with equipment used by someone else?** |  **Yes / No** |
| **Expression of Interest completed by:** |
| **Worker name:** |  | **Signature:** |  | **Date:** | **/ /** |

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|  |
| Client consent to share information |  | **Young person**Cliient consent to Share InformationName:      Date of Birth: dd/mm/yyyy    /    /    Sex:       |

**Section 1: My information explained**

I have discussed with my worker what’s involved with the Bunjilwarra program and I understand how my personal information will be used and handled, that it will only be used for the purpose outlined in this form and any other purpose or additional information collection will need my permission. I do not have to give consent to collection of this information but this may compromise the quality of the treatment / support I am given.

I understand that my information will only be seen by the Bunjilwarra staff involved in my care and service improvement. Bujilwarra will only release identifiable information about me if I agree or if required by law, such as a medical emergency, or if there is a serious threat to my health and well-being or that of someone else.

Bunjilwarra has an obligation to report critical incidents to the agency that funds its program. I understand that if I am ever involved in a critical incident I will be asked at that time for my consent for identifiable personal information about my involvement to be released for the purpose of reporting and investigating.

**Section 1: Personal/health information to be shared**

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| --- | --- | --- | --- |
| **Service Type**Examples:– physiotherapy– counseling | **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 |
| *AOD Healing Service* | *Bunjilwarra* | All relevant information | Referral & care co-ordination |
|       |       |       |       |
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**Section 2: Record of consent**

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| [ ]  **Written consumer consent** Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:    /    /    Witness: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:    /    /    **or**[ ]  **Verbal consumer consent** **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. |

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 *& between the Bunjilwarra Healing Service* [ ]

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. *Explain that all workers have a duty of care to disclose information about a client who is threatening harm either*
to themselves or to another person. [ ]

4. Provide the consumer with information about privacy. [ ]

5. Provide the consumer with a copy of this form once completed.

 [ ]

**BUNJILWARRA EMERGENCY DISCHARGE PLAN**

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| --- | --- | --- | --- |
| **Resident Name:** |  | **Date of Birth:** |  **/ /** |

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| --- |
| **Details of Legal Guardian (for minors)** |
| **Contact Name:** |  | **Relationship to Resident:** |  |
| **Home Phone:** |  | **Business Phone:** |  |
| **Mobile:** |  | **Other:** |  |

This plan is designed to give the young person short term support in the event they have to leave Bunjilwarra on short notice. This plan needs to have been discussed with all people concerned and agreed on prior to coming to Bunjilwarra.

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| **Plan in case of emergency discharge:** |
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| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of resident) agree to the above plan in the event that I decide to leave, or staff request that I leave immediately. |
| **Signed:** |  | **Date:** |  **/ /** |

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| **For Minors** |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of guardian) agree to the above plan in the event that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of resident) decides to leave Bunjilwarra unrepentantly, or is asked to leave by staff. |
| **Signed:** |  | **Date:** |  **/ /** |

PO Box 43 Hastings, VIC 3915

ph: 03 5979 2011

fax: 03 5979 3211

email: info@bunjilwarra.org.au

**BUNJILWARRA EXPRESSION OF INTEREST CHECKLIST**

**Very Important:**

To ensure that your referral is considered for assessment - please ensure that **ALL** the following paperwork has been fully completed and signed by all relevant parties:

* Expression of Interest form, all pages and areas completed.
* Client Consent to Release/Obtain Information form. *This needs to indicate the names and contact details of all Care Team members and people the young person is agreeing we can share information to and from.*
* Emergency Discharge Plan. *This needs to indicate where the Young Person may decide to go and who is to be contacted, if they are leaving Bunjilwarra with short notice.*

**Other important information that will assist with referral/assessment:**

* Legal reports; *Correctional and/or Youth Justice Orders.*
* Medical reports: *physical health reports.*
* Mental health reports; *Past assessments and discharge summaries of recent hospitalisations.*

**MUST HAVE - Before admission to Bunjilwarra:**

* Pathology results for 3 clean supervised urine tests
* Medication – *reduction regime for Benzodiazepine and levels done on the UDS.*
* *Contact details for Prescriber and Chemist use for Pharmacotherapy medications.*
* Cannabinoids – where needed, levels done on the UDS.
* Centrelink: CRN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Payment type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payment Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTE: If payment is inactive for any reason then the payments must be reinstated prior to being admitted into Bunjilwarra

* Birth certificate – original or certified copy

Other identification required:

* Medicare card: card number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ reference number \_\_\_\_\_\_\_\_\_\_\_
* Proof of age care (if applicable)
* Driver’s license (if applicable)