



INTEGRATED **WELLBEING**
SERVICE

IWS Consent and Referral Form

Referrer to complete forms and email to iws@focusonehealth.com.au

CLIENT CONSENT

Integrated Wellbeing Service (IWS) Service Providers are required to collect personal information from you so we can contribute to the provision of quality health care. In doing so, we would like your permission to collect this information and it is important that you understand and sign this document.

IWS Partners, Staff and Service Providers will comply with relevant privacy legislation for personal information outlined in our Policy, Procedures and Practice Guidelines. The IWS team will work closely with other agencies to coordinate the best support for you and your family. Your informed consent for the sharing of information will be sought and respected in all situations unless:

- We are obliged by law to disclose your information regardless of consent or otherwise
- It is unsafe or impossible to gain consent or consent has been refused, and,
- Without information being shared, it is anticipated a child, young person or adult will be at risk of serious harm, abuse or neglect, or pose a risk to his or her own or public health safety.

Consent (please tick all that apply)

☐ I have read and understood the above privacy information and understand the IWS team will act in accordance with Privacy Act 2002 and all other relevant Government laws and regulations.

☐ I understand that I do not have to give information asked, but not doing so may limit the range of services available to me.

☐ I understand that I can withdraw my consent at any time.

☐ I agree to the collection of my personal information and use of my de-identified information as detailed in this Client Consent Form.

☐ I agree my information may be provided to and used by a replacement health service provider, a new health provider who provides a similar service, my GP, anybody or organisation that funds services provided by the IWS Partners or other health care providers who are involved in my care.

☐ I agree that my services if needed can be delivered by telehealth. (E.G. telephone/web-based/skype)

☐ I give consent that in the event, FocusOne Health is no longer funded to provide this service, my personal information will be forwarded to a subsequent service provider.

Please print name:		Signed:	
Name of Legal Guardian (if signing on the client's behalf):		Date:	

Information contained in this referral form is private/confidential. If you are not the intended recipient, any use, disclosure or copying of this document is unauthorised under the Health Care Act 2008 and may attract a fine of up to \$10 000. If you have received this document in error, please contact the referrer.

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The Integrated Wellbeing Service is a partnership initiative of
FocusOne Health, Summit Health and Murray Mallee General Practice Network



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REFERRAL FORM

SERVICE DETAILS

Service Location: _____ Date of referral: _____

CLIENT DETAILS

Name: _____ DOB: _____

Home Number: _____ Mobile: _____

Next Of Kin Name: _____ Relationship: _____ Number: _____

Private Health: **Hospital:** ☐ **Extras:** ☐ **Both:** ☐

GPMP/TCA INFORMATION

☐ Current GPMP/TCA **to be attached to this referral**

If there is **NO** GPMP/TCA in place:

Reason: _____

HEALTH INFORMATION

Chronic Disease: _____ Other Conditions: _____

Observations: Height: _____ Weight: _____ Waist: _____ BMI: _____ BP: _____

☐ Current Health Summary **to be attached to this referral**

SERVICES REQUIRED

Care Planning and Coordination Services (e.g. assistance to access Allied Health and / Specialist Nursing services, or assistance to access additional supports where appropriate/relevant/beneficial)

Allied Health Services: (Please tick)

☐ Physiotherapist ☐ Podiatrist ☐ Exercise Physiologist ☐ Dietitian
☐ Nutritionist ☐ Diabetes Educator ☐ Occupational Therapist ☐ Asthma/Respiratory Nurse

Specialist Nursing Services:

Other, please specify: _____

Healthy Lifestyle Education and Support: _____

DOCTOR SIGNATURE

GP Name: _____ Signature: _____

Nurse Practitioner (transitional referral): _____ Date GP Signed: _____

**Please email IWS Consent and Referral Form (as per above details).
Thank you for your referral to the Integrated Wellbeing Services.**

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