**New Client Record and Informed Consent Form**

**Informed Consent** - It is your right to make informed decisions about your treatment, including the decision to commence and or cease treatment at any time. This includes access to information which helps you make decisions regarding your treatment. Your mental health professional will discuss with you any questions you have including but not limited to; what your treatment entails, confidentiality, data collection, your client record, costs and missed appointments. If you require a support person or interpreter, to understand any of the information given to you, regarding your treatment, please let your mental health professional know.

**Information on Client Records** - As part of its contract with the ACT Department of Health, Meridian Inc. is required to maintain client records in accordance with the ACT Health Records ACT 1997. The form enables us to meet this requirement and provide optimal services to our clients. Client Records show:

* Which particular services have been accessed (e.g. Counselling, Case Management etc.)
* the staff member responsible
* the date and the hours involved
* Any brief notes relevant to improving the co-ordination of support services for that particular client.

When accessing Inclusive Pathways, if you provide consent, some information will be provided by Capital Health Network (CHN) to the Department of Health for statistical and evaluation purposes. This information **will** include details about you such as date of birth, gender and types of services you use, but **will not include** your name, address or Medicare number.

**Confidentiality and Privacy -** Client Records are stored on a computerised cloud-based database, with multiple password protection. It is **only** accessible to authorised Meridian staff involved in Client Services. Clients should be aware that all staff at Meridian are required to sign and adhere to a Confidentiality Agreement.

Clients have the right to consent (or not) to confidential information being disclosed, except where serious risks (i.e. imminent self-harm, harm to others, a major crime, child protection, mandatory reporting) or the law, warrant exceptions. In very rare situations, information subpoenaed by a court of law or requested under Chapter 16A of the Child and Young Person (Care and Protection) Act 1998 is exempt from confidentiality. Meridian is legally obliged to comply with a subpoena and supply your file notes. Your counsellor/case manager will talk with you first, before any action is taken.

**Access to Information -** At any time, you can request access to the information held about you and a suitable time will be arranged. **At no time** will your Client Record be made available to any other agencies or organisations, or be made accessible to anyone other than yourself or Meridian Client Services staff, without your express permission. Any reporting requirements to the ACT Department of Health will **not** identify you in any way.

**Missed/Cancelled Appointments for Wellbeing Services and Client Services** - We understand that on some occasions it may be difficult to attend your appointment. If you are unable to attend an appointment for any reason, please advise us as soon as possible, so that another client can be offered the time slot.

* Meridian –(02) 6257 2855
* Meridian Wellbeing Services – 0412 882 855 or [wellbeingservices@meridianact.org.au](mailto:wellbeingservices@meridianact.org.au)
* Meridian Client Services 0438 623 101 or support@meridianact.org.au

If you miss your appointment, we will attempt to contact you to rebook a suitable alternative time. If we cannot reach you, then please contact us directly to re-book, which may include adding you to a waitlist.

The maximum number of appointments that you can miss without notification is two.

**I have a right to:**

**Respect**

* All care is delivered in accordance with relevant Commonwealth, state/territory legislation, related Acts, and Meridian policies and procedures.
* To have my needs understood in a way that is meaningful to me and appropriate services are engaged when required to support this.

WE ARE MERIDIAN.

WE ARE A PEER-LED, COMMUNITY-CONTROLLED ORGANISATION.

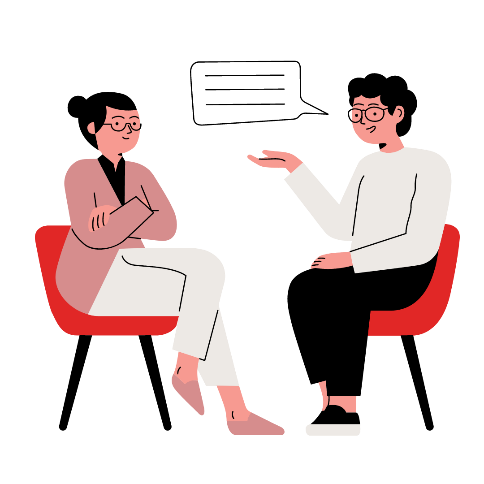
WE CELEBRATE DIVERSITY, STRENGTHEN COMMUNITY AND EMPOWER INDIVIDUALS TO LIVE THEIR BEST LIVES.

* To be treated with respect and dignity by all people at Meridian
* To have my culture, identity, beliefs and choices recognised and respected

**Care**

**Safety**

* To feel safe and secure while accessing services



If my behaviour does not respect other people or if I engage in unlawful or illegal activity on the premises I will be asked to leave and access to services of the Meridian may be restricted. Please discuss any concerns regarding the code of conduct with a member of staff.

* To not attend Meridian premises whilst under the influence of alcohol or drugs.
* To not be involved in any unlawful activities or behaviour while using the service. These include but are not limited to:
* Using or dealing illegal drugs
* Verbally or physically threatening or assaulting another person
* Stealing or damaging property belonging to clients, staff or other visitors
* Giving false information in order to gain financial or other assistance
* To let staff know if your circumstances change
* To attend your appointments with Meridian workers and if unable to attend make every effort to contact Meridian 24 hours prior to your appointment.

**Keep others safe**

* To actively participate in my individual service planning
* To let staff know if my circumstances change
* To attend my appointments with Meridian workers and if unable to attend make every effort to contact Meridian 24 hours prior to your appointment.

**Assist**

* To respect the privacy and confidentiality of other people who use the Meridian services
* To treat everyone with respect and courtesy, and to speak politely to staff and other service users

**Respect**

**I have a responsibility to:**

* To choose an advocate, support person, or carer to speak on my behalf
* To have an interpreter present so that I can speak on my own behalf
* To have my suggestions, feedback or complaint treated seriously without fear of being disadvantaged in any way

**Privacy**

**Access**

* To access services and programs depending on eligibility

**Information**

* To be given information to assist me to make informed, confident choices about the services you receive
* To be involved in planning my care as well as deciding what services are most appropriate for my needs
* To withdraw my consent to release personal information at any time
* I can request access to my own record in accordance to relevant Commonwealth, state/territory legislation and a suitable time will be arranged.

**Be heard**

* To have my information treated confidentially and have my privacy maintained to the extent that it does not impose serious risk to me or others.

***Please provide the name and pronouns you would prefer to be used with Meridian. If your legal name is different you may share this with us if it becomes relevant***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Name and address are optional, but a unique identifier is required to allow consistency across services.* | | | | | |
| First name: | | Pronouns: | | | |
| Surname: | |
| Address: |  | | | | |
| Suburb: |  | | State: | Postcode: \_\_\_\_\_\_\_\_\_\_\_ | |
| If your address is not in the ACT – do you work or study in the ACT? | | | | □ Yes | □ No |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Mobile Phone: |  | | | | Can we contact you via SMS? | | | | | | □ Yes □ No |
| Home Phone: |  | | | | | | | | | | □ N/A |
| Work Phone: |  | | | | | | | | | | □ N/A |
| E-mail: |  | | | | | | | | | | |
| Country of birth: |  | | | | | | Date of birth: / / | | | | |
| Preferred method of contact: | | | | □ SMS | | □ Phone | | | | □ Email | |
|  | | | | | | | | | | | |
| How would you describe your Gender identity? | | | | | | | | | | | |
| □ Agender | | □ Trans woman/girl | | | | | | | □ Female | | |
| □ Gender fluid | | □ Brotherboy | | | | | | | □ Male | | |
| □ Gender Queer | | □ Trans man/boy | | | | | | | □ Questioning | | |
| □ Non-binary | | □ Sistergirl | | | | | | | □ Another term | | |
| □ Do not wish to disclose | | Please feel free to tell us more: | | | | | | | | | |
|  | | | | | | | | | | | |
| How would you describe your sexual orientation? | | | | | | | | | | | |
| □ Lesbian | | | □ Gay | | | | | □ Bisexual | | | |
| □ Queer | | | □ Asexual | | | | | □ Heterosexual | | | |
| □ Do not wish to disclose | | | □ Another term (please provide details): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | □ Don’t know | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Do you have a Trans experience? | | | □ Yes | □ No | □ Do not wish to disclose |
| Were you born with a variation in sex characteristics also known as intersex? | | | □ Yes | □ No | □ Do not wish to disclose |
|  | | | | | |
| Do you identify as: | □ Aboriginal | □ Torres Strait Islander | | | □ Aboriginal & Torres Strait Islander |
| □ Neither | □ Do not wish to disclose | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Are you of a culturally and linguistically diverse background? | | □ Yes | □ No |
| Language(s) spoken at home other than English? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | □ N/A |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Emergency Contact *(optional)*: *The contact should be a person you authorise us to contact in case of emergency.*  Has this person been notified that they are your emergency contact? Yes / No *(please circle)* | | | | | |
| Name: |  | | | Relationship: | |
| Address: |  | | | Mobile Phone: |  |
| Suburb: |  | | | Work Phone: |  |
| State: |  | Postcode: |  | Home Phone: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Carer *(optional)*: *This is a person who provides you with personal care, support and assistance with activities of daily living.*  Do you consent to us liaising with your carer as part of your recovery journey? Yes / No *(please circle)* | | | | | |
| Name: |  | | | Relationship: | |
| Address: |  | | | Mobile Phone: |  |
| Suburb: |  | | | Work Phone: |  |
| State: |  | Postcode: |  | Home Phone: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Do you have a health care card? | | | □ Yes | | | □ No | |
| What is your main form of income? | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Are you currently working? | | | □ Yes | | | □ No | |
| If yes, how frequently? | □ Full-time | | | □ Part-time | □ Casual | | □ Other |
| Do you have a mental health treatment plan? | | | | | □ Yes | | □ No |
| Do you have any requirements that would enable you to better access the service? | |  | | | | | |

I agree that I have read and understood the information contained on and in this form (New Client Record and Informed Consent Form). I agree that I have asked for further clarification and understanding where required and that I have received information and answers to my satisfaction. I voluntarily consent to proceed with treatment and/or access to services.

I consent to my information being provided by Capital Health Network (CHN) to the Department of Health

Please Tick to be used for statistical and evaluation purposes. I understand that this will include details about me such

as date of birth, gender and types of services I use but, will not include my name, address or Medicare number.

I understand that my information will not be provided to the Department of Health if I do not give consent.

|  |  |
| --- | --- |
| Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Office Use only | | | | | | | | | |
| Initial Contact Date: | |  | | | | | Staff Member: | |  |
| Referred to Meridian by: | | | | | | | | | |
| □ Self | □ GP | | □ CSHC | | | □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Referred to: | | | | | | | | | |
| □ Other Meridian services | | | | □ GP | □ CSHC | | | □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

Notes: