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| **ACRONYMS**  |  |
| **CISS** | Child Information Sharing Scheme  |
| **FVISS** | Family Violence Information Sharing Scheme  |
| **FV** | Family violence |
| **ISE** | Information Sharing Entity as prescribed under CISS and/or FVISS |
| **RAE** | Risk Assessment Entity as prescribed under CISS and/or FVISS.  |

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| **WHEN TO USE THIS FORM** |
| The External Entity Request for Information form is completed by external entities requesting information from Eastern Health when they do not have their own form.  |
| **STEPS TO COMPLETE THIS FORM** |
|  | **Verify your ISE/RAE status** |
|  | Eastern Health can only share information with ISEs or RAEs as prescribed under *Part 5A of the Family Violence Protection Act 2008*. To find out if your organisation is an ISE or RAE, an online list has been developed: https://iselist.www.vic.gov.au/ise/list/.  |
|  | **Consent requirements** |
|  | Health professionals are encouraged to seek consent to share information from the individual (adult or child victim survivor or third party) where it is appropriate, safe and reasonable to do so even when consent is not required under the Schemes. **If obtaining written consent, please attach either your own consent form or the consent form provided at the end of this form**. |
|  | **Requesting information** |
|  | Please ensure you provide sufficient information for the reason for requesting information to assist Eastern Health to identify what information we hold may be relevant and whether information should be released.  |

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| **Section 1. Details of Requesting Entity**  |
| **Service name:** | **Contact person:**  |
| **Phone number:** | **Email:** |
| **Requesting entity:** FV Risk Assessment Entity (RAE) [ ]  FV Information sharing entity (ISE) [ ]  CISS ISE [ ]  |
| **Details of the request (scheme):** FVISS [ ]  CISS [ ]   | **Date of request:** |
| **Purpose for sharing information:** FV Risk Assessment/Protection [ ]  Wellbeing or safety of a child [ ]  |
| **Is the request urgent:** Yes [ ]  No [ ]  *\*Eastern Health has a target response time of 5 business days* |
| **Section 2. Person information request relates to** |
| **Full Name:** | **DOB:** | **Gender:** |
| **Address:** |
| **Section 3. Consent (where practical attach consent form)** |
| [ ]  Adult Victim Survivor  | **Consent:** Adult Victim Survivor[ ]  Consent received [ ]  Consent declined [ ]  Request relates to child victim survivor – consent not required |
| [ ]  Child Victim Survivor (under 18)  | No consent required for any person |
| [ ]  Perpetrator/Alleged Perpetrator  | No consent required from (alleged) perpetrator |
| [ ]  Third Party  | **Consent:** Third Party Adult Victim Survivor[ ]  Consent received [ ]  Consent declined [ ]  Request relates to child victim survivor – consent not required  |
| **Consent:** Third Party Child Victim Survivor[ ]  No consent required from any person  |
| **Consent:** Third Party (Alleged) Perpetrator[ ]  No consent required from any person  |
| **If consent is required, how was consent obtained?** Written *\*attach consent form* [ ]  Verbal [ ]  Implied [ ]   |
| **For information requested about a child or a victim-survivor/third party, were their views obtained in relation to the information being shared**? Yes [ ]  No [ ]  If no, why? |
| **Section 4. Content of the Request** |
| **Please provide background to support the request, including nature of family / child violence concerns and safety risk factors.**  |
| **Information requested** |
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| Please email completed form to relevant department:* **Mental Health Program –** InformationSharingMentalHealth@easternhealth.org.au
* **AOD (Turning Point) –** InformationSharingTurningPoint@easternhealth.org.au
* **ECASA –** Ecasa.Intake@easternhealth.org.au
* **General Hospital & all other Eastern Health Programs –** inforelease@easternhealth.org.au
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**PATIENT CONSENT TO REQUEST INFORMATION**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name) consent to the collection, use and sharing of my personal information under Part 5A of the *Family Violence Protection Act 2008*. I understand that my information may be shared without consent if there is a serious threat to myself or another individual’s life, health, safety or welfare. I also understand that my information may be shared without consent if it is relevant for assessing or managing risks to a child victim survivor of family violence.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name (print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Worker signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name (print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Verbal consent obtained**: [ ]  Yes [ ]  No Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate your preferred contact method:**

**Mail Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone:**
 Would you prefer to be called from a private number: [ ]  Yes [ ]  No
 What is the best day and time for us to call? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Text message**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A message left with an authorised person for you to return the call:

**Authorised Person’s contact details:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_