

## Ngunnawal Bush Healing Farm

The Ngunnawal Bush Healing Farm Service will provide a place of healing, whereby Aboriginal and Torres Strait Islander peoples will feel safe and supported by the traditional custodians, community leaders/elders, respected role models as well as cultural healers to make ongoing and meaningful changes in their lives.

The NBHF will use a therapeutic community approach, using traditional healing concepts, cultural programs and life skills training to tackle the client's underlying social and emotional issues.

Our clients can expect our staff and service providers to deliver:

- opportunities to re-connect to country and culture, including facilitate tracing of cultural lineage;
- an introduction to Aboriginal and Torres Strait Islander dance, song and art;
- an opportunity to learn about cultural protocols, practices and understanding of LORE;
- share techniques on self-empowerment and building resilience;
- receive social and emotional wellbeing support; and
- undertake any training and specific courses to assist with employment opportunities.

At all times clients, staff and service providers will maintain respect for themselves and others.

**Please make sure all pages are completed as the agency referral form may not be progress if incomplete. Please submit all referrals via email to [NBHF\\_Referrals@act.gov.au](mailto:NBHF_Referrals@act.gov.au)**

## Criteria for entering Ngunnawal Bush Healing Farm checklist

Is the Client:

- Of Aboriginal and/or Torres Strait Islander origin?
- Is 4-6 weeks abstinent from Alcohol and Other Drugs
- Ready to enter the Ngunnawal Bush Healing Farm Day Program and participate Monday's to Thursday's for the 10 week Day Program?
- Willing to learn respectfully about their Aboriginal and/or Torres Strait Islander origin?
- Able to benefit from attending the Ngunnawal Bush Healing Farm?
- Willing to work on all aspects of their life socially, spiritually, emotionally, mentally and physically in conjunction with their support workers, referring agencies and other agencies support workers at Ngunnawal Bush Healing Farm feel they may need to be referred to?
- Willing to remain abstinent from all Drugs and Alcohol while attend the Program?

If Client meets all Criteria please complete Agency Referral Form.

**All clients will need to undertake an interview with the Cultural Evaluation Panel, who will consider the client's cultural readiness to participate in the Ngunnawal Bush Healing Farm programs, activities and services.**

## Client Details

|                  |  |               |  |
|------------------|--|---------------|--|
| Client Full Name |  | Date of Birth |  |
| Address          |  | Home          |  |
| Email            |  | Mobile        |  |
| Place of Birth   |  |               |  |

|                  |  |              |  |
|------------------|--|--------------|--|
| Referring Agency |  | Date         |  |
| Name of contact  |  | Phone Number |  |

## List any other support services the client is involved with

| Agency | Support Person | Support client is receiving and contact details |
|--------|----------------|---|
|        |                |   |
|        |                |   |

## Reason for Referral

As part of this Referral, please attach a summary of any known AOD, Mental Health and criminal history.

## Medication

NBHF requires information about current medication clients are on, if there are any changes to medications Staff at NBHF need to be notified. Please Note ALL medications

| MEDICATION NAME<br><i>e.g. Amoxicillin</i> | DOSE<br><i>e.g. 500 m</i> | REQUIRED<br><i>e.g. 4xdaily</i> | Reason For Medication<br><i>e.g. infection</i> |
|--|---------------------------|---------------------------------|--|
|  |                           |                                 |  |
|  |                           |                                 |  |
|  |                           |                                 |  |

## Consent to Share and Obtain Information Form

The Ngunnawal Bush Healing Farm Service (NBHF) ensures that client's personal information is confidential and treated respectfully. However there are some exemptions to confidentiality including; where the client has consented to share information, where NBHF staff identify a real risk of harm to the client or another party, or where information is subpoenaed by a Court or other services with similar powers i.e. Probation and Parole or Care and Protection.

All Client records are stored securely, and all NBHF staff may access, if needed.

I, ..... understand that my records are stored in a secure file and if I participate in the NBHF Program, information relating to my participation may be shared between staff of the service. I also give permission for my personal information to be disclosed to, and obtained from, the persons and services listed below if necessary. I understand that I have a right to withdraw consent at any time.

| Services/ Agencies               | Contact Person and number | Consent Yes/No |
|----------------------------------|---------------------------|----------------|
| Mental Health Services           |                           |                |
| Alcohol and Other Drug Services  |                           |                |
| Health Service/ GP               |                           |                |
| Corrective Services              |                           |                |
| Legal Representatives            |                           |                |
| Department of Housing            |                           |                |
| Community Services               |                           |                |
| Diversion Services (MERIT/CADAS) |                           |                |
| Centrelink                       |                           |                |
| Department of social services    |                           |                |
| Hospital                         |                           |                |
| Family Members                   |                           |                |
| Other                            |                           |                |

This consent is valid for a period of 12 months only.

Start Date ..... End Date .....

I have read and understood the information provided above:

Client Name:..... Signature.....

Witness Name:..... Signature.....

### Health and Social Inclusion Evaluation Panel Use

Comments on Health Referral Form information:

Outcome (please circle)

Deemed suitable for entry

Deemed not suitable for entry

Delegate Name:.....

Delegate Signature:.....

Date:.....