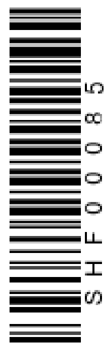


Monash Health

☐ Dandenong Hospital ☐ MMC – Clayton
☐ Kingston Centre ☐ MMC– Moorabbin
☐ Jessie McPherson ☐ Community Health Services
☐ Casey Hospital ☐ Cranbourne Integrated Care Centre

Unit Record Number: ....

Surname: ....

Given Name: ....

D.O.B: .... Age:.......... Sex: ....

Affix Patient Identification Label

Family Violence and Child Information Sharing Request Form

Requesting Agency Details:

Agency name:		Date	
Contact name:		Ph.	
Email			

Is your agency an Information Sharing Entity (ISE): ☐ Yes ☐ No
Is your agency a Risk Assessment Entity (RAE): ☐ Yes ☐ No

Information request is for:
(select all that apply)

☐ **Family Violence Information Sharing Scheme (FVISS) request:**
☐ Risk assessment purposes ☐ Protection purpose

☐ **Child Information Sharing Scheme (CISS) request:**
☐ Make a decision or assessment ☐ Provide a service
☐ Initiate or conduct an investigation ☐ Manage risk

Subject of the request

☐ Alleged perpetrator ☐ Victim survivor - adult ☐ Child or group of children
☐ Perpetrator ☐ Victim survivor - child ☐ Third party

Subject Full Name: DOB: Gender:

Address: Phone:

Consent

Is consent required to share the information in the circumstances? ☐ Yes ☐ No

Consent must be obtained from adult victim survivors (with no children in their care) or third parties. No consent required from alleged perpetrator/perpetrators,child victim survivors or where there is a serious threat.

Was consent obtained? ☐ Yes ☐ No
If yes, from whom?

If consent was not obtained, why?
☐ Alleged perpetrator/perpetrator
☐ Assessing or managing risk to a child victim survivor
☐ Serious threat to life, health, safety or welfare
☐ Other:

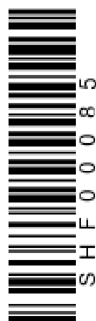
Is this request urgent? ☐ Yes ☐ No If yes, reason:

Outline the context of this request: Eg, Identify all Affected Family Members (AFM), Person Using Violence (PUV) and their relationship, L17 narrative, date of family violence incident, are children involved? (including child safety wellbeing concerns, Child Protection), any risk factors present	**What risk relevant information is being requested?:** Eg, reason for admission, date of discharge, referral / support in place

Please email completed form to: ISS@monashhealth.org

SENSITIVE

Family Violence Protection Act (2008) *Child Wellbeing and Safety Act* (2005)



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Unit Record Number: ....
Surname: ....
Given Name: ....
D.O.B: .... Age:............ Sex: ....

Affix Patient Identification Label

OFFICE ONLY - MONASH HEALTH

Family Violence team to complete:			
Date request received:		Authenticity of requestor confirmed:	☐ Yes ☐ No
Is the requesting agency an ISE?	☐ Yes ☐ No		
Is the requesting agency a RAE?	☐ Yes ☐ No		
Is the information requested for: • A family violence risk assessment purpose (*this information can only be shared with RAEs)* • A family violence protection purpose • Promote the wellbeing / safety of a child or group of children			☐ Yes ☐ No

Delegated employee to complete:			
Information is NOT to be shared if it meets the **exclusion criteria**: • Endanger a person's life or result in physical injury • Prejudice legal proceedings or a police investigation • Is restricted from being shared under other laws	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	*If 'yes' to any question, information cannot be shared*	
Do you recommend the information be shared?	☐ Yes ☐ No - reason:		
Employee Name:		Position	
Consulted with, name (if applicable):		Position	

MONASH HEALTH RESPONSE:

Enter risk relevant information that is recommended to be released, add additional page/s if needed:

General Manager or Family Violence Team to complete:			
General Manager, Name:		Position:	
Family Violence Team, Name:		Position:	
Date agency notified:		If information was not shared, was agency notified:	☐ Yes ☐ No
Family Violence Team to email completed form to: **SMRdata@monashhealth.org**			

SENSITIVE

Family Violence Protection Act (2008) *Child Wellbeing and Safety Act* (2005)

Family Violence and Child Information Sharing Request Form