

## REQUEST FOR MENTAL HEALTH CONSUMER REPRESENTATION

### Service and Activity Information

REQUEST DATE		NAME OF SERVICE	
REGION		REQUESTED BY (NAME)	
PHONE NUMBER		EMAIL	

A FUNDING SOURCE FOR THIS REQUEST MUST BE APPROVED BY YOUR SERVICE'S MANAGER	
ESTIMATE NUMBER OF HOURS	_____ HOURS
OTHER REIMBURSEMENT OFFER (please specify)	
NAME OF MANAGER MAKING THIS APPROVAL	

### Role Details

ACTIVITY, PROJECT, PANEL OR COMMITTEE NAME	
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BRIEF DESCRIPTION OF ACTIVITY
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WHY IS CONSUMER REPRESENTATION BEING REQUESTED? WHAT IS THE INTENDED PURPOSE OF LIVED EXPERIENCE REPRESENTATION, AND HOW WILL THIS INVOLVEMENT INFLUENCE OUTCOMES FOR THE SERVICE AND CONSUMERS?
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### Date/Timeframe of Activity

#### ONE-OFF PLACEMENT

DAY & DATE		START TIME		FINISH TIME	
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#### ONGOING PLACEMENT

MEETING DAY		START DATE / TIME		FINISH DATE / TIME	
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INDICATE WEEKLY / MONTHLY / QUARTELY. PROVIDE APPROX. TIME FRAME IF NOT YET KNOWN
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APPROX. No of HOURS REQUIRED (including meeting & preparation time)	
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LOCATION & ADDRESS of MEETING / ACTIVITY	
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## Name & Contact Details of Placement Support Person

<b>NAME</b>		<b>PHONE</b>	
<b>EMAIL</b>			

<b>DOES THIS ACTIVITY RELATE TO REPRESENTATION ON A COMMITTEE? IF YES, PLEASE ATTACH A COPY OF THE TERMS OF REFERENCE AND OTHER RELEVANT DOCUMENTS</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>DOES THIS ACTIVITY RELATE TO REPRESENTATION ON A SELECTION PANEL? IF YES, PLEASE ATTACH RELEVANT DOCUMENTS.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>WILL THIS ACTIVITY BE LIKELY TO MAKE THE REPRESENTATIVE PRIVY TO INFORMATION THAT MAY CAUSE STRESS (eg serious incident review findings)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**IF YES, WILL SUPPORT BE PROVIDED AND HOW WILL IT WORK? (eg debrief after meeting, follow-up calls, notify MHLET)**

**PLEASE IDENTIFY ANY ISSUES REGARDING CONFIDENTIALITY OR SENSITIVE DATA ASSOCIATED WITH THE ACTIVITY.**

**HOW WILL THE REPRESENTATIVE RECEIVE ASSOCIATED DOCUMENTS / PAPERS?**

Email  Post  Other (please specify):

<b>IS VIDEO CONFERENCING AVAILABLE AS AN OPTION?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>IS TELEPHONE CONFERENCING AVAILABLE AS AN OPTION?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>HOW WILL THE REPRESENTATIVE BE NOTIFIED OF MEETING TIME OR DATE CHANGES? (keeping in mind that Representatives may not have access to outlook calendars)</b>	<input type="checkbox"/> Email <input type="checkbox"/> Mobile / Phone
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## Perspective, Skills & Experience Required

### Consumer Representative

*A person with a lived experience of mental illness providing advice and input based on their own unique, individual experience.*

### Broad Consumer Representative

*A consumer representative providing a broad perspective of the lived experience, based on consultation with a range of people with a lived experience of mental illness.*

## Please Identify Areas of Skill and/ or Experience Required

**EXAMPLES INCLUDE AREAS OF LIVED EXPERIENCE REQUIRED, SKILLS OR KNOWLEDGE REQUIRED, AND TRAINING OR BRIEFING REQUIRED.**

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<b>PLACEMENT No.</b>			
<b>NAME OF CONSUMER REPRESENTATIVE APPOINTED</b>		<b>DATE</b>	