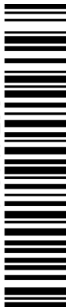


MR/118.1



# Echuca Regional Health

## INFORMATION SHARING FVISS & CISS

SURNAME: ..... UR NO: .....

GIVEN NAME: .....

DOB: ..... SEX: ..... WARD: .....

DOCTOR: .....

USE LABEL IF AVAILABLE

### INSTRUCTIONS FOR USE

- Requesting **Information Sharing Entities (ISE)/Risk Assessment Entity (RAE)**'s are to email completed form to [foi@erh.org.au](mailto:foi@erh.org.au)
- Information sharing helps keep victims of family violence safe and hold perpetrators to account
- Information sharing between prescribed services is approved under state government ministerial guidelines:
  - Child Information Sharing Scheme (CISS) Part 5A Family Violence Protection Act 2008
  - Family Violence Information Sharing Scheme (FVISS) Part 6A Child Wellbeing and Safety Act 2005
- This form supports the safe transmission of relevant information between approved service providers
- **Prescribed ISE/RAEs' are listed in the ERH CISS and FVISS Policy**
- Information Sharing Enquiry Line 03 9143330 or 1800 549 646 [informationsharing@familysafety.vic.gov.au](mailto:informationsharing@familysafety.vic.gov.au)

### CHILD INFORMATION SHARING SCHEME/FAMILY VIOLENCE INFORMATION SCHEME

Which ISE/RAE has ERH requested information from:

Name: ..... Ph: ..... Email: .....

**OR** Which ISE/RAE has requested information from ERH or Voluntarily Sharing Information:

Name: ..... Ph: ..... Email: .....

Is the requesting agency a confirmed ISE/RAE:  Yes  No Refer policy to confirm prescribed ISE/RAE  
If **NO**, do not continue with this process

Name of the person requesting information: .....

Role of the person requesting information: .....

Is this request related to Child Information Sharing (CISS):  Yes  No

Is this request related to Family Violence Information (FVISS):  Yes  No

Date of request for information was received from other ISE/RAE: .....

Date request by ERH/Voluntarily Sharing to another ISE/RAE was sent: .....

- For whom is information to be shared about:
- |  |                               |
|--|-------------------------------|
| <input type="checkbox"/> Child/Children      | } Consent <b>NOT</b> required |
| <input type="checkbox"/> Adult               |                               |
| <input type="checkbox"/> Adult third party   |                               |
| <input type="checkbox"/> Perpetrator         | } Consent <b>NOT</b> required |
| <input type="checkbox"/> Alleged perpetrator |                               |

Was this information shared with consent:  Yes  No

If yes to above, describe how consent was recorded:  Information Sharing Consent Form MR/118

Other: .....

If no, provide reason information was shared **WITHOUT** consent: .....

ERH Staff Member Name: .....

Designation: .....

Signature: .....

Date information sent / received: .....

How was information sent / received: .....

**ENSURE PASSWORD PROTECTION OR DATA ENCRYPTION USED. KEEP COPY OF ANY REQUEST IN PATIENT FILE.**  
Requests will be responded to via secure email within 2 business days,  
unless relating to immediate safety or urgent responsive needs.

VER 1  
APR  
2021



INFORMATION SHARING FVISS & CISS

MR/118.1

# Echuca Regional Health

## INFORMATION SHARING FVISS & CISS

SURNAME: ..... UR NO: .....

GIVEN NAME: .....

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USE LABEL IF AVAILABLE

Why is the information required?

To make a decision, assessment or plan  To initiate or conduct an investigation  To provide a service  To manage a risk

Other .....

Were the views obtained from the child or their parent (non perpetrator)?  Yes (outline with request)  No

**PURPOSE OF  
INFORMATION  
REQUESTED  
OR  
SHARED**

**INFORMATION  
REQUESTED  
OR  
INFORMATION  
SHARED**

**RISK  
CONSIDERATIONS**

**ACTIONS**

*Consider referrals, report to Child Protection, safety plan, monitoring  
If request not being actioned, why?*

Name: ..... Designation: .....

Signature: ..... Date: ..... / ..... / .....