**Date of Referral: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

|  |  |
| --- | --- |
| **Eligibility Criteria** | |
| * **headspace** Indooroopilly accepts referrals for young people aged between 12 and 25 years. * Referrals from QLD Health require a copy of ALL relevant collateral information (including assessment, discharge summaries and recovery documents) prior to referral being processed. * Referrals from Probation and Parole require information on convictions and pending legal matters including dates, along with AOD information prior to referral being processed. * Please note that referrals will NOT be processed without signed consent from the Young Person. | |
| **Young Person’s Details** | **Contact for appointment booking *(direct contact with the young person is always preferred where possible)*** |
| First Name: | Name: |
| Last Name: | Phone: |
| Address: |  |
|  | **Reason for Referral** |
| Phone: | Counselling/Mental Health Services 🞎 |
| Sex: Male 🞎 Female 🞎 Other 🞎 | Drug and Alcohol Intervention 🞎 |
| Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | Social Recovery Groups 🞎 |
| Has the young person consented to this referral? Yes 🞎 No 🞎 | Health Review / GP Services 🞎 |
| Young Person’s Signature: |  |
|  | **Current Living Environment** |
| **Indigenous Status** | Live Alone 🞎 |
| Aboriginal / Torres Strait Islander Yes 🞎 No 🞎 | Home with Parents 🞎 |
|  | Home with Care Giver 🞎 |
| **Referrers Information** | Other (e.g. Crisis Accommodation) 🞎 |
| Name: |  |
| Position: | Contact attempts made (headspace Use Only): |
| Organisation: |  |
| Phone: |  |
| Signature: |  |

|  |  |
| --- | --- |
| **Presenting Issues *(please tick all that apply)*** | |
| 🞎 Anxiety | 🞎 Refusing to attend school |
| 🞎 Depression | 🞎 Self-Harm |
| 🞎 Harm or threats to others | 🞎 Stress |
| 🞎 Suicide ideation | 🞎 Crying / Ongoing Distress |
| 🞎 Difficulty sleeping | 🞎 Drug use |
| 🞎 Alcohol use | 🞎 Low self esteem |
| 🞎 Pain management issues | 🞎 Financial issues |
| 🞎 Family relationship issues | 🞎 Physical abuse |
| 🞎 Relationship issues | 🞎 Sexual abuse |
| 🞎 Hallucinations & delusions | 🞎 Eating problems |
| 🞎 Body image issues | 🞎 Bullying others |
| 🞎 Victim of bullying | 🞎 Pending legal matters |
| 🞎 ADHD / ADD | 🞎 Loss of appetite |
| 🞎 Physical disability | 🞎 Intellectually impaired |
| 🞎 PTSD / History of Trauma | 🞎 Social problems at school |
| 🞎 Asperger’s / Autism | 🞎 History of hospitalisation |
| 🞎 Presentation to ED / Hospital | 🞎 Past or present contact with DOCS |
| 🞎 Criminality | 🞎 Other *(please specify)* |
|  |  |
| **Other agencies/health professionals currently involved with the young person’s care** | |
|  | |
|  | |
|  | |
|  | |
|  | |
| **Additional Information you wish to provide** | |
|  | |
|  | |
|  | |
|  | |