**headspace Orange Referral Form**

Once completed please email to: hs.orange@marathonhealth.com.au

**Does the young person (YP) know about this referral?** Yes [ ]
Have they given consent for this information to be exchanged? Yes [ ]
**Is the YP between 12 and 25 years of age?** Yes [ ]

*If not, the referral cannot be accepted. Get in touch and we’ll talk you through some other options.*

**If under 16 years, are the parents/carers aware?** Yes [ ]

**Is this young person at IMMEDIATE risk of harm to themselves or other people?** [ ]  Yes [ ]  No

**headspace** is an early intervention and prevention service. If the young person is currently at risk of harm to themselves or to someone else, they are not suitable for **headspace** services. Please either contact the Mental Health hotline on 1800 011 511 (24 hours) for appropriate services, take them to your nearest hospital or call 000.

|  |  |
| --- | --- |
| *Name* |  |
| *Date of Birth* |  |
| *Cultural Identity* | [ ]  Aboriginal [ ]  Torres Strait Islander [ ]  Both [ ]  Other ………………………………............................................................... |
| *Gender* |  |
| *Address* |  |
| *Who with?* | [ ]  At home with family [ ]  Living alone[ ]  Staying with friends [ ]  Homeless[ ]  Refuge [ ]  Supported accommodation  |
| *YP Phone Number* |  |
| *Email (optional)* |  |
| *Name of parent/guardian for young people 16 years and under* |  | *Parent/guardian contact number:* |

**Who is the best person to contact about this referral?** YP [ ]  Parent/Guardian [ ]  Referrer [ ]

**Is YP at school, TAFE, University or working?** Yes [ ]  No [ ]

|  |
| --- |
| 1. What has led to this referral to **headspace**? What are the current concerns? |
| 2. Is the YP at **non-immediate** risk of harm? Are there any identifiable risk factors? (e.g. thoughts of suicide, self-harm, harm towards others, risk-taking behaviours, substance use, risk of homelessness)   |
| 3. Anything else happening that might be affecting the YP? (e.g. family issues, exam stress, issues with friends or relationships)  |
| 4. Anything from the past that might be affecting the YP now? |
| 5. Any previous mental health support/treatment, counselling, medication or diagnoses? |
| 6. What does the YP feel would be useful about coming to headspace, what are their goals? How motivated are they to come?  |
| 7. Any other information that may be relevant? (e.g. family history of mental health issues, court involvement, intellectual disability, physical disability) |

 **Does YP have a GP?**  Yes [ ]  No [ ]

|  |  |
| --- | --- |
| *GP Name* | *Medical Centre / Practice* |

**Is there a current Mental Health Treatment Plan?** Yes [ ]  No [ ]

**Does the YP have an NDIS plan?** Yes [ ]  No [ ]

**Any other workers/services involved?**

|  |  |
| --- | --- |
| *Name* | *Position / Organisation / Contact number* |

**Referrer details**

|  |  |
| --- | --- |
| Name: | Position / Organization: |
| Email: | Best contact number: |
| Referrer signature: | Date: |

*Headspace use only*

SRI noted in file title: Yes ☐ No ☐ N/A ☐

Escalated to Senior Clinical/Lead: Yes ☐ No ☐ N/A ☐