**You can complete this form yourself or call headspace Wagga and we can help you to complete the form over the phone.**

**Free call 1800 856 572 or (02) 6937 9000.**

headspace Wagga Wagga is not a crisis service.

For any immediate concerns, please call Accessline on 1800 800 944

Accessline is a free 24-hour phone service staffed by mental health practitioners.

Date of Referral:

## Consent

headspace Wagga is a voluntary service for young people aged 12-25 years of age. We can only engage with young people if they have consented to the referral and are old enough to consent.

If you are referring a young person, have they consented to this referral? [ ] Y [ ]  N [ ]  N/A

If you are under 14 years of age, has a parent/guardian consented to the referral? [ ] Y [ ]  N [ ]  N/A

## Personal Information of Young Person

|  |
| --- |
| Young person’s full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred name and pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What is your gender identity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Age \_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Young person’s Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Young person’s Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred contact Person & Phone Number/Email (for appointments only):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ UnsureAre you a refugee or from a migrant family/community: ☐ Y\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ N ☐ Unsure.  |
| Services Interested in☐ Mental Health & Wellbeing ☐ eating disorder ☐ DBT group ☐ Alcohol & Other Drugs☐ Work and Study ☐ Dietitian ☐ Doctor/GPIs there anything you would like us to note so we can better support you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

## Service Access information- Current

Do you have an existing General Practice/Doctor: [ ] Y\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  N [ ]  Unsure

Are any other services supporting you or your family at the moment: [ ] Y\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  N [ ]  Unsure

Do you have an existing Mental Health Treatment Plan: [ ] Y\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  N [ ]  Unsure

Do you have an existing counsellor: [ ] Y\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  N [ ]  Unsure

Have you accessed counselling sessions services this calendar year: [ ] Y [ ]  N, *If yes, how many? \_\_\_\_\_\_\_\_*

Do you have any current Court Orders (AVO, DVO, parole/probation): [ ] Y [ ]  N [ ]  Unsure

*If yes:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a NDIS plan: [ ]  Y [ ]  N *If yes, does it include Psychology:* [ ]  Y [ ]  N

(If yes, the young person will not be eligible to receive psychology/mental health services at hWW. The young person may be eligible for other hWW services however.)

## Risk

|  |
| --- |
| In the past two weeks, have you deliberately harmed yourself/had thoughts of harming yourself: [ ]  Y [ ]  N In the past two weeks, have you thought about ending your life: [ ]  Y [ ]  N Have you ever tried to end your life? [ ]  Y [ ]  N *If yes, and you are comfortable, please provide additional information:when/how/ what happened/what was happening in your life at that time:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

## Referrer details

 [ ]  Self (no need to complete below) [ ]  Family or friend *(complete below)* [ ]  Professional *(complete below)*

Referrers’ Name/Organisation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to young person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referrer’s Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referrer’s Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referrer’s Address (*only required if no email provided)*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Please note: For family and friend and professional referrers’, we will continue to liaise with the young person from this point, unless/until consent is provided from the young person.

**How to submit this form:**

In Person: Drop into headspace Wagga at 2/185 Morgan Street, Wagga Wagga

Fax: (02) 6937 9045

Email: myheadspace@headspacewagga.org.au

Mail: PO Box 5693, Wagga Wagga BC, NSW 2650