MUNITY REFERRAL FORM

Referrer to complete form, fax (07 4661 1099) or email ([headspace.warwick@rhealth.com.au](mailto:headspace.warwick@rhealth.com.au)) to headspace Warwick and follow-up with phone call to ensure receipt of referral.

**Referral criteria** – 12-25 years old; not acute; early intervention. **If a young person is at immediate risk of harm, please call 000.**

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| **Date of Referral:** | | | | | | | | |
| **Client Details:** | | | | | | | | |
| Name: | | | DOB: | | | | Gender: | |
| Address:  Parent/Carer (if required): | | | Phone:  Phone: | | | | | |
| **Referrer’s Details:** | | | | | | | | |
| Name: | | | Position: | | | Phone:  Fax: | | |
| Organisation: | | | Address: | | | | | |
| **Reason/s for Referral:** | | | | | | | | |
| Is the client linked with other services? | | If “Yes”, please provide details: | | | | | | |
| 🞎 Yes 🞎 No | |  | | | | | | |
| **CLIENT CONSENT** | | | | | | | | |
| This referral must be discussed with the client. **headspace** Warwick is unable to contact them without their consent. | | | | | | | | |
| Do you have the client’s consent for this referral? *(Where possible, please have the client sign below)* | | | | | * Yes | | | * No |
| If under 16 years of age, are the parents/carers aware of this referral? | | | | | * Yes | | | * No |
| Client signature: |  | | |  | Date: | | |  |
| Referrer’s signature: |  | | |  | Date: | | |  |

**Please note**: **headspace** Warwick will contact the referrer to advise of the young person’s **attendance** or **non-attendance** at **headspace** Warwick. Specific details of the outcome of the contact will not be discussed unless the young person has provided their consent to release of information.MENTAL HEALTH NURSE ICENTIVE PROGRAM