Service Provider Referral Form

Once complete please send this form to:

Fax: (02) 9193 8089 or

Email: headspaceintake@newhorizons.net.au

headspace Ashfield

Young person's details

Date of Referral :

Surname: First name:

Gender: Age: Date of birth:

Address:

Suburb: Post code:

Can we leave a message? Yes ☐ No ☐

Home Phone: Mobile:

Can we leave a message? Yes ☐ No ☐

Is the young person of Aboriginal and/or Torres Strait Islander origin? ☐ Aboriginal ☐ Torres Straight Islander ☐ Both ☐ Neither

Educational Status (highest level obtained): School/Institution:

Occupation: Employment Status:

If no longer at school/work, how long has this been the case?:

Is the young person on any Centrelink payments? (if so please list):

Consent

At headspace Ashfield, it is our standard practice to obtain a parent or guardian's consent for young people under 16 years of age.

Has the young person consented to the referral: ☐ Yes ☐ No (If no, the referral cannot be accepted)

If the young young person is under 16 years of age, are the parents/carers aware of this referral?

☐ Yes ☐ No (If no, the referral cannot be accepted)

Referrer Details

Name: Relationship to young person:

Organisation:

Address: Suburb: Post code:

Email: Contact number:

GP Details

Name: Provider Number:

Address:

Mental Health Treatment Plan created? Date of plan:

Next of Kin details

Next of Kin name: Relationship:

Address: Phone:

Can we contact next of kin? ☐ Yes ☐ No, unless in emergency ☐ If young person is not contactable

Presenting Problem

What is the main reason for this referral? Please include comment on symptoms, current functioning, mental and physical health concerns, school attendance, family issues, drug/alcohol and vocational issues.

Are there any other contributing issues?

Is the young person at risk of harming themselves or others? Detail: (Aggressive behaviour, Suicide/ self harm, Plan, Access to Means, History of Attempts, Lethality, NSSI)

Has the young person ever received prior mental health care or are they currently receiving treatment? (by whom/dates/medications/ please include any hospital admissions):

If there is a discharge summary or other relevant documentation, please attach more information and detail as necessary.

Please note that headspace is not a Crisis or Emergency Service.
In the event of a Mental Health Crisis, please call the NSW Mental Health Line on: 1800 011 511.

In an emergency, call 000 or go to a hospital emergency department.

Office Use Only.

Date of Referral:

Assessment Date:

Referral Method:

MasterCare Team:

Young Person entered into HAPI?