

**Referral Form**

**To be completed by services wishing to refer a young person**

**to headspace Bairnsdale**

**Referral Criteria and Guidance**

**headspace** Bairnsdale is a free, youth-friendly and confidential service available to young people aged 12-25 years, in the Bairnsdale and surrounding area. The services available at **headspace** Bairnsdale include:

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| * Counselling with a psychologist or social worker
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| * Child and adolescent psychiatrist appointments
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| * Alcohol and drug workers
* Employment assistance
* Centrelink appointments
* Allied Health Clinic
* Therapeutic and support groups
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**headspace** Bairnsdale work with young people experiencing mild to moderate mental health issues such as stress, anxiety, depression or grief.

**headspace** Bairnsdale is not an acute mental health / crisis service. If you have any immediate concerns regarding the safety of a young person, please call:

Kids helpline: 1800 551 800

Emergency Services: 000

Lifeline: 13 11 14

Please return the completed referral form to:

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| **headspace** Bairnsdale | Phone: 03 5141 6200  |
| PO Box 677 | Email: referrals@headspacebairnsdale.org.au  |
| Bairnsdale, VIC, 3875  |  |

**Self-Referral**

Young people can refer themselves to **headspace** Bairnsdale. Young people are encouraged to contact **headspace** Bairnsdale directly by either phoning, emailing or walk-in to the centre.

**Family and Friend Referral**

Family, carers and friends can refer a young person to **headspace** Bairnsdale. Please contact **headspace** Bairnsdale directly by either phoning, emailing or walk-in to the centre.

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| Young Persons Details |
| Has the young person consented to this referral? [ ]  Yes [ ]  No |
| Name |  |
| Address |  |
| Date of Birth |  |
| Phone Number |  |
| Gender | [ ]  Female [ ]  Male [ ]  Transgender [ ]  Other: |
| Cultural Identity | [ ]  Aboriginal or Torres Strait Islander [ ]  CALD |

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| Referring Service Details |
| Date of Referral  |  |
| Name |  |
| Address |  |
| Organisation |  |
| Position in Organisation |  |
| Phone Number |  |
| Email |  |

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| Reason for Referral:*Please include any information which may be useful to assist with the referral (e.g. mental health, drug and alcohol, vocational / educational or physical health including past / current risk assessments).* |
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| Does the young person have an existing GP? | [ ]  Yes  | [ ]  No | [ ]  Unsure |
| If yes, please detail: |  |  |  |
| Does the young person have an existing Mental Health Treatment Plan? | [ ]  Yes  | [ ]  No | [ ]  Unsure |
| Does the young person require an interpreter? | [ ]  Yes  | [ ]  No | [ ]  Unsure |

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| Risks to Worker Safety: *Please include any known risks and current management strategies.* |
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