**headspace Referral Form**

*Referrer to complete form and fax to* ***(08) 8582 5050***
*or email to* ***referrals@focusonehealth.com.au***

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|---|---|---|---|---|---|---|---|---|
| **Staff member taking referral:** | | | | | | | | |
| **Referral Type** (check box) ☐ headspace ☐ Alcohol & other Drugs ☐ DWSS | | | | | | | | |
| **1. Referrers Details:** (if you are referring yourself, skip to section 2.) | | | | | | | | |
| **Name of referrer:** | | | | **Date of referral:** | | | | |
| **Are you the parent/legal guardian of the young person?** | Yes ☐ | No ☐ | | **Referrer's phone number:** | | | | |
| **Referrer's email address:** | | | | | | | | |
| **Does the young person consent to referral? headspace** is a voluntary service and all young people must consent to and be willing to engage in services. | | | | Yes ☐ | No ☐ | | | |
| **2. Young Person's Details:** | | | | | | | | |
| **Name:** | | | | **DOB:** | | **AGE:** | | |
| **Preferred Name:** (and pronouns): | | | | **Gender:** | | | | |
| **Street Address:** | | | | | | | | |
| **Postal Address:** | | | | | | | | |
| **Email address:** | | | | **Phone:** | | | | |
| **Is the Young Person under 16?** | | | | | | Yes ☐ | No ☐ | |
| **Is the young person's parent/guardian aware of this referral?** | | | | | | Yes ☐ | No ☐ | |
| **Parent / Guardian / Next of Kin/ Emergency Contact** | | | | **Permission to contact:** | | Yes ☐ | No ☐ | |
| **Phone:** | | | | | | | | |
| **Reason for not giving permission to contact parent/guardian** (only required if young person is under 16) | | | | | | | | |
| **GP's name:** | | | | **When did you last see a Dr?** | | | | |
| **Would you like headspace to help you access a Dr's appt?** | | | | | | Yes ☐ | No ☐ | |
| **Have you received Mental Health and or Alcohol & Other Drug services before?** | | | | | | Yes ☐ | No ☐ | |
| **If YES**, please explain: (CAMHS, school counsellor, private etc.) | | | | | | | | |
| **Are you currently engaging with or being supported by any other services?** | | | | | | Yes ☐ | No ☐ | |
| **If YES**, please explain: | | | | | | | | |
| **Do you identify as:** | Aboriginal | Y ☐ | N ☐ | Torres Strait Islander | Y ☐ | N ☐ | Both | Y ☐ N ☐ |
| **Country of Birth:** | ☐ Australia | | | ☐ Other (please state): | | | | |
| **Do you speak a language other than English at home?** | ☐ No | | | ☐ Yes (please state): | | | | |
| **Do you live alone:** | ☐ No (with who): | | | ☐ Yes | | | | |
| **Accommodation:** | ☐ Stable | | | ☐ Unstable | | ☐ No fixed address | | |

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**Please note:** this page is **not** required to be completed if referral is for an Alcohol & other Drugs Brief Intervention

What are the main issues that bring you to **headspace**? What do you want help with?

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| How upset or worried are you about these issues? (On a scale of 1-5 with (1) being not at all and (5) being as worried as possibly be) | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| How often do these issues happen? (on a scale of 1-5 with (1) being not at all and (5) being all the time) | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| How much are these issues interfering in your life? (on a scale of 1-5 with (1) being not at all and (5) dominating my life completely) | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |

What made you decide that now was the right time to seek help?

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If you find coming to **headspace** helpful, what would look different for you and or your family afterwards?

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**Brief Screening**

Date: Time: Youth Access Worker:

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headspace Berri

Please give this page to the Young Person being referred.
(or parent/guardian if under 16 years)

**Thank you** for your referral and response to the above questions. A member of our headspace Berri team will be in contact with you soon to arrange an Intake appointment. Please note, if we are unable to reach you this referral is unable to be actioned.

**headspace** is not an emergency service.
**If you or a young person need immediate support or medical assistance please contact**

**Phone for immediate support**

- **000** (112 from a mobile phone) and request an ambulance (and/or police if required)
- Your local emergency Mental Health Service – Emergency Triage Liaison Service (ETLS) – **13 14 65**

**Contact your local Medical Clinic and or hospital Emergency Department:**

- **Berri**: 1 Cornwall Street - 8582 2855
- **Barmera:** 24 Hawdon Street - 8588 2040
- **Renmark**: 65 Thurk St - 8586 4111
- **Loxton**: 11 Anzac Crescent - 8584 7321
- **Waikerie**: 2 Strangman Road - 8541 3500
- **RiverDocs Emergency Department**, Riverland General Hospital. Maddern Street, Berri - 8580 2642

**Phone a telephone/crisis helpline (24 hours a day, 7 days a week)**

- **Suicide Call Back Service** – 1300 659 467
- **Suicideline** – 1300 651 251
- **Lifeline** – 13 11 14
- **Kids Helpline** - 1800 55 1800 – www.kidshelpline.com.au
- **eheadspace** (9am to 1am AEST) – www.eheadspace.org.au or call 1800 650 890

**eheadspace** Web chat, telephone and email support is available to young people, as well as their families and friends, from 9am to 1am AEST, 365 days of the year