

Referral Form



Important Information About Your Referral

Once this form is complete please fax to headspace Cairns on 4041 6340

Referral criteria: 12-25 years old, early intervention. headspace Cairns often supports clients by referring them to other services where appropriate.

***Please note headspace Cairns is not an acute mental health/crisis service. If the client is high risk or in a crisis please contact Cairns Child and Youth Mental Health Service (12-17yrs) on 4226 3400 or the Acute Care Team (18+yrs) on 1300 642 255**

Young Person's Details

Full Name:

Date of Birth:

Gender:

Address:

Suburb:

Postcode:

Phone Number:

Email Address:

Preferred Person to Contact:

Contact's number or email:

Does the young person identify as: Aboriginal Torres Strait Islander Both

Parent/Caregiver's Details (If the Young Person is under 16 years of age, we require a parent or caregiver to be documented on this form)

Full Name:

Relationship to Young Person:

Phone Number:

Can we contact this person if the client is unavailable? Yes No

Referrer's Details

Full Name:

Organisation:

Designation:

Phone Number:

Fax Number:

Email:

Primary Reason for Referral

- Counselling Alcohol and Other Drugs Support
 Physical and/or Sexual Health Needs Vocational/Employment

Presenting Issues and Relevant History

Please attach any relevant assessment notes, discharge summaries, and/or additional information

Current Support

Is the Young Person currently, or have they previously been, engaged with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> General Practitioner | <input type="checkbox"/> Public Mental Health Service | <input type="checkbox"/> Drug and Alcohol Services |
| <input type="checkbox"/> Private Practitioner | <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Employment Services |
| <input type="checkbox"/> Homelessness Provider | <input type="checkbox"/> Child Protection Agency | <input type="checkbox"/> Juvenile Justice/Corrections |

Other Please specify:

What do you hope headspace Cairns can achieve for this client?

Authorisation of referral by client

- I am aware that this referral is being made.
- I understand that I can withdraw from this referral or from the referred service at any time.
- I give permission for headspace Cairns to use my contact details above for future contact with me.
- I give permission for headspace Cairns staff to obtain further information relevant to this referral.

Signed: _____ Print Name: _____ Date: _____

*If the young person is under 18 years of age, consent should be provided by a parent/guardian
(if possible and/or appropriate):*

Parent/Guardian Signed: _____ Print Name: _____ Date: _____

Doctors please note: If the client is eligible for a **Mental Health Treatment plan (2715 or 2717)**, attaching a copy of the plan to this referral will speed up their wait time for an appointment with an allocated clinician.