

# headspace Edinburgh North

## Community Referral Form



Referrer to complete form, fax to Sonder on 8252 9433 and follow-up with a phone call to ensure receipt of referral. All details must be completed or referral shall be returned.

Please note: Medium to High risk young people may not be appropriate for this service.

Emergency mental health services can be contacted by calling 8161 7000 (under 18) or 13 14 65 (over 18).

Date of Referral:	
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### Client details

Name:			
DOB:		Gender:	
Address:		Phone:	
Parent or Guardian name:		Phone:	
Does the client identify as an Aboriginal and/or Torres Strait Islander or of a Culturally and Linguistically Diverse background?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

### Referrer details

Name:		Phone:		Fax:	
Organisation and Address:					

**Reasons for referral: (e.g. depression, substance use, anxiety, vocational assistance, etc)**

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**Tick each of the following options.**

Is the young person currently having thoughts of suicide that you are aware of?  No

Does the young person have a current plan to end their life that you are aware of?  No

If you have answered YES to either of the above questions please contact us immediately on (08) 8209 0700 to discuss the referral suitability with the Clinical Lead.

If you are concerned about this person's risk to themselves or others, please indicate how

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**GP details**

Does the client have an existing GP?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>If yes, please provide details below.</i>		
Can we contact them?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
GP Name:		Phone:		Fax:	
GP practice location/address:					

**Consent for Referral**

I, \_\_\_\_\_ (young person), agree to be referred to headspace Edinburgh North and give my permission for \_\_\_\_\_ (Referrer's full name) to provide/receive written and verbal information to/from headspace Edinburgh North for the purpose of facilitating this referral.

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For clients under 16 years (signed consent required by parent/guardian):**

Carer name: \_\_\_\_\_ Carer signature: \_\_\_\_\_