Referral Guidelines

**About headspace Emerald:**

Opening hours:

Monday: 10:00AM – 5:00PM

Tuesday: 10:00AM – 5:00PM

Wednesday: 10:00AM – 7:00PM

Thursday: 10:00AM – 7:00PM

Friday: 09:00AM – 3:00PM

headspace Emerald is a free or low cost, youth friendly and confidential service, providing brief and early intervention services for young people aged 12-25 years experiencing low-moderate mental health concerns.

headspace Emerald provides support with-in these four core streams:

1. Mental health and wellbeing
2. Physical and sexual health
3. Alcohol and other drugs
4. Vocational and educational

**Eligibility criteria:**

headspace Emerald is an early intervention service for young people aged 12-25 with mild to moderate mental health concerns.

* Referrals from QLD Health require a copy of ALL relevant collateral information (including assessment, discharge summaries, & recovery documents) prior to the referral being processed.
* Referrals from Child Safety require a copy of ALL relevant collateral information (including assessment, care arrangements, & court orders) prior to the referral being processed.
* Referrals from Youth Justice or Probation and Parole require a copy of ALL relevant collateral information (particularly regarding risks), along with AOD (Alcohol and Other Drugs) information prior to referral being processed.

**How Does Headspace Emerald Achieve This?**

* identifying the young person’s holistic wellbeing concerns and goals through a comprehensive assessment
* providing evidence based clinical brief interventions
* supporting the young person with appropriate mental health and psycho-social supports in the community and online
* delivering early intervention-based group programs and prevention tools via mental health literacy sessions, workshops, or presentations

**Please Note:**

headspace Emerald is not an acute mental health/crisis service. If you have any immediate concerns regarding the safety/wellbeing of a young person, please call: 1300 MH CALL (1300 642255), Lifeline on 13 11 14; or Kids Helpline on 1800 55 1800. In an emergency, contact 000 immediately.

**How To Refer:**

**Self-referral**

Young People are encouraged to make contact with headspace Emerald directly. We understand this can be a new experience, so support from a referrer during the initial meeting would be appreciated, if required.

**By phone/email**

Call 1800 950 722 or email [intake.headspaceemerald@anglicarecq.org.au](mailto:intake.headspaceemerald@anglicarecq.org.au) and a headspace team member will call you back to make an appointment within 1 – 2 working days.

**Drop in**

Young people can call into headspace Emerald, 65 Hospital Road, between business hours, Monday – Friday. Staff will endeavor to see the young person the same day or the next available appointment will be offered.

**Professional referral**

GP’s, Allied Health Professionals, community-based agencies, and educational institutions can all refer young people to headspace Emerald using the Referral Form attached. General Practitioners should include a mental health care plan (if appropriate) for the young person and attach this to the headspace Emerald referral form.

**Family referral**

Families, carers, or friends can refer a young person to headspace Emerald. The young person needs to be aware of and consent to the referral and be willing to meet with a member from the headspace Emerald team. Once receipt of referral has been confirmed, a worker will contact the young person within one to two working days to make an appointment. Families, parents, or carers who have a young person engaged with headspace Emerald can also access our centre to discuss service provision.

Please Note: Referrals will be responded to within 2 working days. If you have not received confirmation of receipt of this referral, please call us on 1800 950 722 or 07 4897 2300.

**headspace Emerald**

65 Hospital Road, Emerald, Qld, 4720

P: 1800 950 722

T: 07 4897 2300

Please send referrals to our intake email: [intake.headspaceemerald@anglicarecq.org.au](mailto:intake.headspaceemerald@anglicarecq.org.au)

For all other inquiries please email: [headspace.emerald@anglicarecq.org.au](mailto:headspace.emerald@anglicarecq.org.au)

Referral Form

**REFERRER DETAILS**

|  |  |  |
| --- | --- | --- |
| Referral Date |  | |
| Organisation Name |  | |
| Program Name |  | |
| Name |  | |
| Position |  | |
| Address |  | |
| Preferred Contact  *(Provide details for at least one contact)* | Telephone: |  |
| Email: |  |

**PARTICIPANT IDENTIFICATION / CONTACT INFORMATION**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | | | | | | | | | | |
| Referral Type (if applicable) | Self | | Walk-in | | | Phone | | Other | | | N/A |
| Current living situation | Accommodated      Homeless | | | | | | | | | | |
| Home Address |  | | | | | | | | | | |
| Mailing Address | Same as above:  Yes  No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| Consent for Referral | Yes     No | | | | | | | | | | |
| Contact Number |  | | | | | | | | | | |
| Email Address |  | | | | | | | | | | |
| Date of Birth *(dd/mm/yyyy)*  *(Age for referral: 12yrs – 25yrs)* |  | | | | Age *(years)* | | | |  | | |
| Medicare Card |  | | | | IRN: | | | |  | | |
| Gender | Male | | | | Female | | | | Other: | | |
| Preferred Pronouns | He/Him | | | She/Her | | | They/Them | | | Other: \_\_\_\_\_\_\_\_ | |
| Caregiver Contact | Name: |  | | | | | | | | | |
| Relationship: |  | | | | | | | | | |
| Telephone: |  | | | | | | | | | |
| Consent to Contact Caregiver | Consent for emergencies:  Yes     No  Consent relating to service delivery:  Yes     No  (Appointment reminders etc) | | | | | | | | | | |
| Primary Nominated Professional?  *(This person will be informed of the participant’s entry into & exit from the service*) | Name: |  | | | | | | | | | |
| Telephone: |  | | | | | | | | | |
| Email: |  | | | | | | | | | |

**ELIGIBILITY CRITERIA**

|  |  |  |
| --- | --- | --- |
| Criteria *(Please tick one)*  ***Reason for Referral*** | mental health | general health *(including sexual health)* |
| alcohol and drug | work and study |
| Main Issues: |  | |
| Pre-existing diagnoses/relevant past history: |  | |
| Other comments in regard to referral |  | |

**YOUNG PERSON RISK FACTORS**

|  |  |  |
| --- | --- | --- |
| Does the client have a current risk assessment? | Yes *(Required to be attached)* | No |

**MEDICATION**

|  |  |
| --- | --- |
| Medication? If yes, what? |  |

**CARER / SUPPORT PERSON INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Carer, family member or other person that may need support? | Yes | No | Not stated |
| If yes, what is the name of this person? |  | | |
| Best contact number for this person? |  | | |

PRESENTING ISSUES

|  |  |  |
| --- | --- | --- |
| Anxiety | Pain Management Issues | ADHD/ADD |
| Refusing School | Family Problems | Financial Difficulty |
| Depression | Physical Abuse | Loss of Appetite |
| Self-Harm | Relationship Issues | Physical disability |
| Harm or threats to others | Sexual Abuse | Intellectually Impaired |
| Stress | Domestic Violence | PTSD/Trauma History |
| Suicidal | Emotional Abuse | School Social Problems |
| Crying | Hallucinations and delusions | Asperger’s/Autism |
| Difficulty sleeping | Eating Problems | History of hospitalisation |
| Drug Abuse | Body Image | Alcohol Abuse |
| Presentation to ED or Hospital | Bullying Others | Low Self Esteem |
| Past or present contact with CS | Pending Legal Matters | Functional decline |
| Other: | | |

**ADDITIONAL PARTICIPANT INFORMATION (Minimum Data Set)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Relationship Status | Never married | Married/De facto | | Separated |
| Divorced | Not Stated | |  |
| Dependents under 18 years | Yes | No | | Not stated |
| Indigenous Status | Aboriginal but not Torres Strait Island origin | | | |
| Torres Strait Islander but not Aboriginal origin | | | |
| Both Aboriginal and Torres Strait Islander origin | | | |
| Neither Aboriginal nor Torres Strait Islander origin | | | |
| Not stated/inadequately described | | | |
| Country of Birth |  | | | |
| Main Language spoken at home |  | | | |
| Sexual Orientation | Straight or heterosexual | | Lesbian, gay or Homosexual | |
| Bisexual or pansexual | | Questioning | |
| Asexual | | Queer | |
| Other | | Not stated | |
| Does the participant have a transgender history? | Yes | No | | Not stated |
| Current living situation | Currently accommodated | | Currently homeless | |
| Currently accommodated but at risk of homelessness | | | |
| Employment/studying status: | Employed | Unemployed | | Currently looking |
| Student | Unknown | |  |
| Other: | | | |
| Do they have a Health Care Card: | If yes Details: | | | |
| Do they have a National Disability Insurance Scheme (NDIS) plan? | If yes Details: | | | |

**ADDITIONAL INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Your preference for introduction of this participant? | Telephone | Online *(Videoconference)* | Face to Face |
| Preferred date, time, and contact number? |  | | |