Please note that headspaceGreensborough is **not a crisis service**. Crisis care can be accessed via Austin CYMHS (12-18yo) 03 9496 3620, Eastern CYMHS (12-25yo) 1300 721 927 or North East Mental Health Triage (all ages) 1300 859 789

headspace Greensborough offers early intervention support for young people aged 12-25 years experiencing mild to moderate mental health difficulties.

Date:

|  |  |  |
| --- | --- | --- |
| **Young Person’s Details**  Young person is aware about and agrees to referral:  Yes | | |
| Title: | Name: | |
| Gender identity: | | DOB: |
| Address: | | |
| Phone: | | Email: |
| Preferred mode of contact:  SMS  Phone call  Email  Letter | | |

|  |  |
| --- | --- |
| Young Person’s Language and Culture | |
| Tick any that apply: | Aboriginal  Torres Strait Islander  Culturally and Linguistically Diverse |
| Does the young person require an interpreter?  No  Yes, please state what language (including Auslan): | |

|  |
| --- |
| Referral Information |
| Does the young person have a Mental Health Plan?  No  Yes |
| Has the young person been vaccinated against COVID-19?   Yes (Fully)  Yes (Partially)  No  Decline to answer/Unknown |
| Other organisations/supports in place (i.e. GP, school wellbeing, family services – please include role and contact information) |
| Risk issues (i.e. suicidal ideation, self-harm, protective issues) |

|  |  |  |
| --- | --- | --- |
| **Emergency Contact** | | |
| Name: | Phone: |  |
| Relationship to young person: |  |  |

|  |  |
| --- | --- |
| **Referrer Details** | |
| Name: | Role: |
| Phone: | Agency: |
| Fax: | Email: |

|  |
| --- |
| **Consent** |
| I, [carer’s name if young person under 16, young person’s name if 16 or over], give consent for this referral to be made and give permission for \_\_\_\_\_ [referrer name] to exchange information with headspaceGreensborough for the purpose of this referral.  Young person/carer signature: Date:  OR Tick if verbal consent was obtained |

Please send through any relevant documentation with your referral (i.e. MHCP, assessments or discharge plan) via email to: [headspacegreensborough@mindaustralia.org.au](mailto:headspacegreensborough@mindaustralia.org.au?subject=Referral) or fax: 03 9435 8621