headspace Griffith

REFERRAL FORM

Date of referral: _____

Has the Young Person consented to this referral being made? ☐ Yes ☐ No

If the Young Person is **under** the age of 14, have their parents or carers given consent to this referral being made? ☐ Yes ☐ No

Have recent community circumstances affected the young person ☐ Yes ☐ No
If so, what? : _____

Young Person Details:

First name:	Surname:
DOB: Age:	☐ Male ☐ Female
Address:	
Postal Address/PO BOX: (If different from above)	
Phone Number:	
Email Address:	

Alternative Contact: *Please note we must have at least **TWO** ways that we can contact the young person

Name:	Phone Number:
Relationship to young person:	

Does the young person identify as being Aboriginal? ☐ Yes ☐ No
Does the young person identify as being Torres Strait Islander? ☐ Yes ☐ No
Does the young person identify as being Aboriginal and Torres Strait Islander? ☐ Yes ☐ No

Services I am interested in:

☐ Mental Health Services
☐ Educational/Job Seeking
☐ Drug and Alcohol
☐ Doctor (bulk billed with current Medicare card)

Please give a brief description of your reasons for referring and the support being required:

_____
_____
_____
_____
_____
_____

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Other Services:

Does the young person have a G.P? ☐ Yes ☐ No

If so, name? : _____

Is the young person linked with any other services? ☐ Yes ☐ No

If so, who? : _____

Does the young person have another counsellor? ☐ Yes ☐ No

If so, name? : _____

Has the young person accessed any sessions in the past year? ☐ Yes ☐ No

If so, when? : _____

Risk

Has the young person deliberately harmed themselves in the past 6 months? ☐ Yes ☐ No

If so, what form? : _____

Has the young person been admitted to hospital in regards to mental health? ☐ Yes ☐ No

If so, when? : _____

Has the young person thought of ending their life in the past 6 months? ☐ Yes ☐ No

If so, was there a plan and intent? : _____

Referrer's Details:

Referrer's name: _____

Organization: _____

Relationship to client: _____

Phone number: _____

*Please note, we will liaise with the client from this point, unless consent is provided by the client.

How to submit this form:

You can drop into our centre located at:

1/26 Ulong Street, Griffith, 2680 – PO BOX 1067

Contact us on:

Telephone: 02 6962 3277 or Fax: 02 6962 6925

Email us on:

Enquiries@headspacegriffith.org.au

Please note: headspace Griffith is not an emergency service

For any immediate concerns please call

Accessline on 1800 800 944 or 000 for an emergency (24 hour service)

Office Use Only:

Allocated date and time: _____ ☐ Entered ☐ Scanned

☐ Accessline contact number provided: **1800 800 944**

☐ eheadspace contact number provided: **1800 650 890**

☐ Kids helpline contact number provided: **1800 551 800**

☐ Lifeline contact number provided: **13 11 44**

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