Referral Form

headspace Griffith is a voluntary service for young people aged 12 – 25 years. headspace can only engage with the young person if they have consented to the referral. Please ensure all sections are completed and legible.			
Date of Referral?			
Is the young person aged 12 – 25 years of age?		Yes ☐	No ☐
Has the young person consented to the referral?		Yes ☐	No ☐
Details of Young Person			
Does the young person consent to provide the following information to headspace and it being store in headspace's client management system and hAPI?		Yes ☐	No ☐
If the young person is under 14 years of age, have the parents or carers of the young person consented to the referral as well?		Yes ☐	No ☐
First Name		Surname	
Preferred name		Gender	
Date of Birth		Pronouns	
Address		Suburb	Postcode
Phone (Home)		Mobile	
Email			
Preferred Method of Contact	Email ☐	Phone ☐	SMS ☐
Nationality			
Interpreting Service Required?	Yes ☐	No ☐	Preferred Language
Do you identify as	Aboriginal ☐	Torres Strait Islander ☐	Aboriginal & Torres Strait Islander ☐
Emergency Contact (we will contact this person if we are concerned about the young person's safety)			
Parent/ Carer/ Guardians Details			
First Name		Surname	
Address		Suburb	Post Code
Phone (Home)		Mobile	
Details Of Referrer (please ensure this section is completed) Please tick if same as above ☐			
Name of Referrer		Organisation	
Address		Suburb	Post Code
Phone (Business Hours)		Phone (Mobile)	
Email		Relationship to the young person	

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Reason/s for Referral			
Wellbeing & Mental Health ☐	General or Sexual Health ☐	Alcohol & other Drugs ☐	Work, School, Study ☐
Main Issue/s			
Relevant Past History			
Additional information supplied /attached? Mental Health Treatment Plan / Discharge summary etc?		Yes ☐	No ☐
Does the young person currently see any other services? If yes, please tick appropriate box/ boxes		Yes ☐	No ☐
Drug and Alcohol ☐	Child Protection ☐	School/ Other Counsellor ☐	Child/ Adolescent Mental Health ☐
Corrective Services ☐	Adult Mental Health ☐	Allied Health/ Non-Government Support ☐	Specialist Medical Services (Psychiatrist/ Paediatrician etc) ☐
Other – Please Specify			
Does the young person have a regular GP? If yes, please provide details below		Yes ☐	No ☐
Name of GP		Contact Details	
Name of Medical Practice		Phone	
Is the other service aware of the referral to headspace?		Yes ☐	No ☐
Will the services currently involved continue working with the young person?		Yes ☐	No ☐

If the young person is experiencing current;

- **Suicidal thoughts**
- **Suicidal plan**
- **Suicidal intent**

Please contact Accessline on 1800 800 944 instead of making this referral as headspace is not a crisis service.

Thank you

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