



Date: _____

Details of young person

First name _____ Surname _____

Preferred name _____ Date of Birth _____

Gender Male Female Other

Pronouns he him his she her hers them their theirs

Language other than English? _____

Does this person identify as Aboriginal or Torres Strait Islander? Yes No

Address _____

Suburb _____ Post Code _____

Email _____ Mobile _____

Medicare # _____ Reference # _____ Expiry _____

Other contact details

emergency contact next of kin preferred contact person

Name _____ Mobile _____

Relationship to young person _____

Service delivery method

face to face Telehealth

Details of referral

(Primary reason for referral)

mental health drug and alcohol vocational GP services groups

other _____

Details of referrer (person completing this document)

Name _____ Relationship to young person _____

Organisation (if applicable) _____

Address _____ Post code _____

Phone _____ Fax _____

Email _____

Does the young person have a mental health treatment plan? Yes No

Will you or another person from your service have continued involvement with the young person? Yes No N/A

Has the young person agreed to this referral? Yes No

In agreeing to this referral, the young person is aware that they may withdraw from the referral or services at headspace Horsham at any time and we will use their contact details above to make future contact directly with them. Referrals will not be accepted without the consent of the young person.



headspace

Horsham

Presenting issues

- Anxiety
- Refusing school
- Depression
- Self harm
- Harm or threats to others
- Stress
- Suicidal thoughts
- Suicidal behaviour
- Difficulty sleeping
- Drug abuse
- Alcohol abuse
- Pain management
- Pending legal matters
- Children under 5
- Other _____
- Family Problems
- Physical abuse
- Relationship issues
- Low self esteem
- Domestic violence
- Emotional abuse
- Hallucinations or delusions
- Eating problems
- History of hospitalisation
- Presentation to hospital
- ADHD or ADD
- Financial difficulty
- Grief and loss
- Pregnant
- Loss of appetite
- Physical Disability
- Sexual abuse
- PTSD or trauma
- Social problems
- Aspergers or Autism
- Body image
- Bullying
- Crying
- Past or present contact with child safety
- Previous incarceration or criminal history

Risk

	NIL	Low	Medium	High	Comments
To self	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
To others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
By others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Is the young person currently linked in with any other services/health care workers?

Please summarise the young person and what you hope headspace Horsham can achieve for them.

Important information about your referral

headspace is a service for young people aged 12-25. We can only engage with young people who are happy and willing to engage and who have provided consent to the referral. headspace Horsham is **not** a crisis service. Please contact emergency services 000 if the young person is in crisis or at acute risk of harming themselves or others.

In a mental health emergency please contact Ballarat Mental Health Services 24-hour call line 1300 661 323.

To provide a complete referral, please provide any additional notes or information that you feel will be beneficial to the care and support we provide and email to info@headspacehorsham.org.au . We will endeavour to respond to referrals within 24-48 business hours, but if you have any queries please phone us on 5381 1543.