

Referral to headspace Morwell

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| *Please ensure all sections are completed and legible.*  *Return via* ***email:*** [*info@headspacemorwell.org.au*](mailto:info@headspacemorwell.org.au) *or* ***fax:*** *(03) 5136 8333* | | | | | | | | |
| **headspace Referral Criteria :** | | | | | | | | |
| headspace is a voluntary service for young people aged between 12 and 25. **We can only connect with Young People if they have consented to the referral and are in this age group.** | | | | | | | | |
| **The Young Person has consented to and provided permission for a referral?** | | | | |  |  | Yes ☐ | No ☐ |
| Is the Young Person aged 12 to 25? | |  |  |  |  |  | Yes ☐ | No ☐ |
| **headspace is not a crisis service.** We are unable to support severe mental health concerns or crisis referrals. **We suggest you please call the Mental Health Triage Line on 1300 363 322** if the young person requires urgent mental health assistance.  **Please call headspace Morwell on (03) 5136 8300 to ensure your referral has been received and to discuss anything further. If we are unavailable, we will respond to you within two working days.** | | | | | | | | |
| **Referrer Details:** |  |  |  |  |  |  |  |  |
| Name of Referrer: |  |  |  |  |  |  |  |  |
| Relationship to Young Person: | |  | Organisation: | |  |  |  |  |
| Contact Number: |  |  |  | Fax: |  |  |  |  |
| Service Address: |  |  |  |  |  |  |  |  |
| Email: |  |  |  |  |  |  |  |  |
|  | |  |  |  |  |  |  |  |
| **Parent/Guardian/Carer:** \* | | | | | | | | |
| Name: |  |  |  |  |  |  |  |  |
| Relationship to young person: | |  | Contact Number: | |  |  |  |  |
| Interpreter Required? Yes ☐ No ☐  Do we have permission to speak with the person identified? Yes ☐ No ☐ | | | | | | | | |
| **Young Person’s Details:** \*please note that if the young person is aged 15 and under, we will require a  parent or guardian to be documented on this form. | | | | | | | | |
| Name: |  |  |  |  |  |  |  |  |
| Date of Birth: | Age: | | Gender: | | | | |  |
| Address: |  |  |  |  |  |  |  |  |
| Suburb: | Post code: | | | | | | | |
| Contact Number 1: | 2. | |  |  |  |  |  |  |
| Cultural Identity: | Language Spoken at home: | | | | | | |  |
| Preferred language: | Interpreter needed: | | | | Yes ☐ No ☐ | | | |
| Indigenous Identity: | Aboriginal ☐ | Torres Strait Islander ☐ | | Both ☐ | Neither ☐ | | | |



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| **Primary reason(s) for Referral:** This section **must** be completed and/or assessment notes attached | | | | | |
| ☐ | **Mental Health Support**  Up to 10 focused, evidence-based counselling sessions  (Mild / Moderate) | | ☐ | **Physical Health Support**  GP or Sexual Health Nurse | |
|  | **Youth Work**  (Low level case management support as specified in care plan) | |  | **Telepsychiatry**  291 referral required from GP | |
| ☐ | **Alcohol and Other Drugs Support** | | ☐ | **Vocation, Education, Training, Employment Support** | |
|  | **Homeless / At risk of homelessness**  Innovative health support for 16 – 25 year olds in the Latrobe Valley that are homeless or at risk of homelessness | |  |  | |
| **Presenting Issues:** | | | | | |
| **If the Young Person has a pre-existing diagnosis, please provide details.** This may include details of  diagnosis, details of diagnosing health professional, previous treatment, etc. | | | | | |
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| **Current presenting issues:** | | | | | |
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| **Other factors?** Is the Young Person currently undertaking or at risk of any of the following: | | | | | |
| * Suicidal | | * Harming self | * Harming others | | * Extreme social withdrawal |
| * Homelessness | | * Substance use | * School avoidance | | * Other |
| Details: | |  |  | |  |
| Referrer Signature: | |  |  |  | Date: |
| **Thank you! If you have any concerns please phone the centre on 5136 8300** 2 | | | | | |