headspace Mount Gambier

Referral Form 8725 0443

Please note: **headspace** Mount Gambier isn't a crisis service, or an acute mental health service.
For emergency mental health support, please contact the emergencies services, on 000.

GPs to complete a Mental Health Treatment Plan. Completed referrals to be emailed to headspacemountgambier@unitingcommunities.org
It is important that the young person is aware of this referral and agrees to attend appointments at **headspace** Mount Gambier.

Young Person's Details:

Full Name:

Date of Birth: Gender:

Phone Number (home and/or mobile):

Address:

Town/Suburb:

Email:

Can we use SMS to confirm appointments? Yes ☐ No ☐

If the young person is under 16, is their parent/caregiver aware of the referral? Yes ☐ No ☐

Family Member/Emergency Contact:

Full Name: Phone Number:

Referrer Information:

Name:

Phone:

Email:

Relationship to young person:

Position and organisation:

Does the young person currently receive support from any other services? Yes ☐ No ☐
If so, please specify who, from which service(s), and their contact details.

Appointments:

☐ headspace - 171 Commercial St East Mt Gambier ☐ Outreach

Who should be contacted to book appointments?

Young person ☐ Referrer ☐ Family Member ☐

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What is the reason for Referral?

Anxiety	☐	Conflict in Relationships	☐	Stress Related	☐	Social Isolation	☐
Depression	☐	Alcohol/Substance Use	☐	Medical Issues	☐	Other	☐

Does the young person have a Mental Health Treatment Plan? Yes ☐ No ☐

Have any relevant assessments been completed? Yes ☐ No ☐
If so, please attach.

Please provide a brief explanation of the reason for referral – what are the presenting issues, and what type of support are you requesting, for this young person?

Are you concerned with this person's risk towards themselves or others? YES ☐ NO ☐

If you have answered 'yes' - please identify how, and provide as much detail as you can.

Please note: Moderate to High Risk young people may not be appropriate for this service.
Mental health services can be contacted on: **CAMHS** 8724 7055 (under 16yo) or
Country SA Mental Health Services 8721 1507 (over 16yo) or
Adult Mental Health Services 24hr Crisis Assistance 13 14 65

I (young person) _____ , being 16 years or older, agree to be referred to **headspace** Mount Gambier and give my permission for (referrer's name) _____ to exchange information with **headspace** Mount Gambier for the purpose of this referral.

I (parent/guardian) _____ agree for (young person) _____ to be referred to **headspace** Mount Gambier and for information to be shared as above.

Young person signature _____ Date / /20

Referrer/Parent/Guardian signature _____ Date / /20

Office Use Only Referral Completed by: Appointment Booked: / / with