**headspace Orange Referral Form**

Once completed please email to: [hs.orange@marathonhealth.com.au](mailto:hs.orange@marathonhealth.com.au)

**Does the Young Person (YP) know about this referral?** Yes   
Have they given consent for this information to be exchanged? Yes    
Phone number of young person to check consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If not, the referral cannot be accepted. Get in touch and we’ll talk you through some other options.*

**Is the YP between 12 and 25 years of age?** Yes

**If under 16 years, are the parents/carers aware?** Yes

**Do you believe this young person is at risk of harm to themselves or other people?**  Yes  No

headspace is an early intervention and prevention service. If the young person is at risk of harm to themselves or to someone else, they are not suitable for headspace services. Please contact the **Mental Health Hotline on 1800 011 511** (24 hours) for appropriate services, take them to your nearest hospital, or call 000.

|  |  |  |
| --- | --- | --- |
| *YP Name* |  | |
| *Date of Birth* |  | |
| *Gender* |  | |
| *Address* |  | |
| *Who with?* | At home with family  Living alone  Staying with friends  Homeless  Refuge  Supported accommodation | |
| *YP Phone Number* |  | |
| *Email (optional)* |  | |
| *Name of parent/guardian (optional)* |  | *parent/guardian contact number:* |

**Is YP of Aboriginal or Torres Strait Islander background?** Yes  No   
**Who is the best person to contact about this referral?**  YP  Parent / Guardian  Referrer

**Is YP at school, TAFE, university or working?** Yes  No

|  |  |
| --- | --- |
| *Where?* | *Year / Level?* |

|  |
| --- |
| 1. What’s led to referring to headspace? What are the current concerns? |
| 2. Is the YP at risk of harming themselves or others? Are there any identifiable risk factors? (e.g. thoughts of suicide, self-harm, risk-taking behaviours, harming others) |
| 3. Anything else happening that might be affecting the YP? (e.g. family issues, exam stress, issues with friends or relationships) |
| 4. Anything from the past that might be affecting the YP now? |
| 5. Any previous mental health support / treatment, counselling, medication or diagnoses? |
| 6. What does the YP feel would be useful about coming to headspace, what are their goals? How motivated are they to come? |
| 7. Any other information that may be relevant? (e.g. family history of mental health issues, court involvement, intellectual disability, physical disability) |

**Referrer details**

|  |  |
| --- | --- |
| *Name* | *Position / Organisation* |
| *Best contact number* | *Email* |
| *Fax* | *Address* |

**Does YP have a GP?**  Yes  No

|  |  |
| --- | --- |
| *GP Name* | *Medical Centre / Practice* |

**Is there a current Mental Health Treatment Plan?** Yes  No

**Does the YP have an NDIS plan?** Yes  No

**Any other workers/services involved?**

|  |  |
| --- | --- |
| *Name* | *Position / Organisation / Contact number* |