headspace Port Adelaide / Thrive Referral Form

Fax to (08) 8312 3025 or email to headspaceportadelaide@centacare.org.au

Date:	Time:
Name of person filling in this form:	☐ Email/Fax ☐ In person ☐ Phone

Is this referral for:

☐ headspace Port Adelaide

Early intervention, short-medium term mental health support for young people aged 12-25 experiencing ***mild to moderate*** *mental health difficulties.*

☐ Thrive
Mental health support for young people aged 16-25 experiencing, or at risk of developing, ***severe and/or complex*** *mental health needs and/or eating disorders.*

Young Person Details

Please confirm young person is aware of and consents to referral: ☐ Yes

Name			
Date of Birth		Age	Gender
Residential Address			
Contact Details	Phone	Email	
Preferred mode of contact	☐ SMS ☐ Phone call ☐ Email ☐ Letter		

Does the young person require support with reading and writing? ☐ No ☐ Yes

Does the young person have a Mental Health Care Plan: ☐ No ☐ Yes Does this young person have a formal mental health diagnosis: ☐ No ☐ Yes ______________________________	Medicare card number: Reference: Expiry date:

Young Person's Cultural Identify	☐ Aboriginal	☐ Torres Strait Islander	☐ Culturally and Linguistically Diverse	☐ None of these
Does the young person require an interpreter?	☐ No ☐ Yes - language:______________________________			

headspace Port Adelaide is funded by the Adelaide Primary Health Network

Family and Friends Contact		
Name		
Relationship to young person:		
Contact Details	Phone	Email
Consent to contact in an emergency:	☐ Yes ☐ No	

For headspace Port Adelaide Referrals only **Reason for Referral (tick as many as apply)**	
☐ Mental health support	☐ Physical health support
☐ Alcohol and other drugs support	☐ Work & study support
☐ Financial counselling	☐ Independent housing support

For Thrive Referrals only – please note that service providers are encouraged to call and speak to the Thrive team before making a referral where possible. **Referral Criteria (all must apply)**	
Age 16-25 ☐ Yes Resides in Adelaide's Western suburbs ☐ Yes Experiencing or at risk of experiencing a **severe and/or complex** mental illness ☐ Yes Requires a mix of multi-disciplinary, multi-agency approaches to meet their mental health care needs ☐Yes	
Seeking support for a diagnosis of/risk of diagnosis of at least one of the following:	
☐ Eating Disorder	☐ Severe Anxiety Disorder
☐ Bipolar Affective Disorder	☐ Borderline Personality Disorder
☐ Post-Traumatic Stress Disorder	☐ Severe Depressive Disorder
☐ Psychosis (referrals for first episode of psychosis should be instead directed to headspace Youth Early Psychosis Program at https://headspace.org.au/headspace-centres/adelaide/)	

Consent

I, _________________________ [carer's name if young person under 16, young person's name if 16 or over], give consent for this referral to be made and give permission for ________________________ [referrer name] to exchange information with **headspace** Port Adelaide / Thrive for the purpose of this referral.

Young person/carer signature: ______________________________ Date: _______________________________

Referrer Detail

Source of Referral:

Referring Person			
Address/ Agency			
Phone:	Mobile	Fax	Email
Relationship/Position			

Referring worker's name and signature

_____________________________________**Date:**________________________

Please note that **headspace** Port Adelaide/Thrive are not crisis services. Crisis care can be accessed via Western CAMHS (<16) on (08) 8161 7000 or Mental Health Triage (>16) on 13 14 65

Office Use Only Medicare Checks			
MHCP Current Y/N	Date of Visits Left	**GP Care Plan** Current Y/N	Date of Visits Left