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| headspace is not a crisis service. We are unable to support severe Mental Health concerns or crisis referrals. Please call the 24hr Mental Health Line on 1800 011 511 if the young person requires urgent assistance. |

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| SECTION 1 - headspace referral criteria |
| headspace is a voluntary service for young people 12 - 25 y.o. We can only engage if the young person has consented to and provided permission for this referral. Has this occurred? Yes No |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| SECTION 2 - YOUNG PERSON’S DETAILS: | | |
| NAME: Click here to enter text. GENDER: Click here to enter text. | | DOB: Click here to enter text. Age: Click here to enter text. |
| Address: Click here to enter text. | | |
| Suburb: Click here to enter text. | Mobile no.: Click here to enter text. | |
| Alternative contact no.: Click here to enter text. | Email: Click here to enter text. | |
| Country of birth: Click here to enter text. | Interpreter: Yes No / Cultural Background: Click here to enter text. | |
| ATSI:  Aboriginal  Torres Strait Islander  Both  Neither | | |
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| SECTION 3 - Referrer details: headspace will be corresponding with you using the details below. Please ensure that all details are correct and legible | |
| Self-referral:  Yes  No | Organisation: Click here to enter text. |
| Referrer name: Click here to enter text. | Designation: Click here to enter text. |
| Relationship to young person: Click here to enter text. | Fax no.: Click here to enter text. |
| Phone no.: Click here to enter text. | Email: Click here to enter text. |
| Service address: Click here to enter text. | |

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| SECTION 4 - Parent/guardian: \*please note that if the young person is aged under 16 or if there are identified risk issues we will require a parent or guardian to be documented on this form | |
| Name: Click here to enter text. | |
| Relationship to young person: Click here to enter text. | Contact no.: Click here to enter text. |
| Do we have consent to speak with the young person identified?  Yes  No | |

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| SECTION 5 - Primary reason(s) for referral: this section must be completed. Please attach any additional information/assessment notes | |
| Mental health support | Physical health support |
| Drug and alcohol support | Educational/vocational support |
| Social inclusion | Other, please specify: Click here to enter text. |

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| SECTION 6 - Presenting issues: | |
| Does the young person have a mental health care plan?  Yes  No  Unknown | |
| *Current Presenting issues*: (this section must be completed)  Click here to enter text. | |
| *Please list other services involved:* Click here to enter text. | |
| *GP Details:* Click here to enter text. | |
| *Risk factors for young person/family:* | ***Details:*** |
| Suicidality | Click here to enter text. |
| Aggression | Click here to enter text. |
| Homelessness | Click here to enter text. |
| Non-suicidal self-injury | Click here to enter text. |
| Substance use | Click here to enter text. |
| Risky behaviour | Click here to enter text. |
| Acute Psychiatric | Click here to enter text. |
| Other | Click here to enter text. |

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| OFFICE USE ONLY | |
| Intake worker recommendation/appointment made: | |
| Who will attend appointment: Written consent gained: | |
| *MMEX:* | *TRAKCARE:* |