headspace Rockhampton Referral Form

On completion of this form, please fax to: (07) 4994 2538
For any queries, please contact (07) 4994 2512

Important information regarding your referral, please read:

- headspace Rockhampton is an early intervention service for young people between the ages of 12 to 25.
- We can only engage with young people who have provided consent to the referral.
- If the young person is experiencing high levels of distress which may result in harm to themselves or others, or is at high or acute risk of suicide, please refer them directly to the Emergency Department or contact emergency services on 000 as headspace Rockhampton is not a crisis service or equipped to manage these types of emergencies.
- Please note that receipt of the referral does not indicate acceptance to the headspace Rockhampton services. Suitability of the referral will be determined following assessment with the young person.
- Please provide and attach as much information as possible as it ensures the best quality of care, outcome and if required referral, is afforded to the young person being referred.
- Referrals from QLD Health require a copy of ALL relevant collateral information (including assessment, discharge summaries and recovery documents) prior to the referral being processed.
- Please note we are a voluntary service.

Referrer details: headspace will be corresponding with you using the below details. Please ensure that all details listed below are correct and legible.

Name of Referrer:			
Organisation (if applicable):			
Position / Relationship to Young Person:			
Postal Address:	**Suburb:**	**Postcode:**	
Contact Number:		**Fax Number:**	
Email Address:			
Do you wish to be part of our mailing list?	☐ Yes ☐ No		

Primary reason(s) for Referral: This section must be completed. Please contact us if you have any queries regarding available services.

☐ Short-term Mental Health Intervention

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

☐ Drug and/or Alcohol Support	☐ Vocational Support
☐ Physical Health Support	☐ Other, please specify: _____

Young Person's details:					
Name:					
Date of Birth:		**Age:**		**Gender:**	
Address:	**Suburb:**			**Postcode:**	
Contact Number:		**Safe to leave a message?**	☐ Yes ☐ No		
Interpreter Required?	☐ Yes, Language: _____		☐ No		
Assistance with Reading or Writing?	☐ Yes ☐ No				

Parent/Guardian: This section is only required for young people under 18 years of age. For this age group, **headspace** Rockhampton suggests ensuring parent/guardian(s) are aware of the referral.			
Name:			
Relationship:		**Contact Number:**	
Are parent/guardian(s) aware of this referral?	☐ Yes ☐ No		
Do we have consent to speak with the carer identified?	☐ Yes ☐ No		

Presenting Issues:

Current presenting issues (please include duration, age of onset, and relevant pre-existing diagnoses):

Impact of problem on functioning: (e.g. relationships, school, home, work)

Please indicate if there is any known family history of mental health conditions:

Previous/current engagement with other services: (please include contact information, and if current– relevant assessment information should be attached)

Risk Factors:

☐ Suicide	☐ Deliberate self-harm	☐ Harm to others	☐ Domestic/Family Violence
☐ Homelessness	☐ Accidental death	☐ Social Isolation	☐ Child Safety involvement
☐ Substance use	☐ Non-compliance	☐ Social withdrawal	☐ Other: _____

Please provide details:

Consent: Where possible, have the young person sign this referral. If verbal consent is obtained, please ensure the following information is provided to the young person and consent for below is given.

I am aware that this referral is being made. I understand that I can withdraw from this referral or from the referred service at any time.

I give permission for headspace Rockhampton to use my contact details above for future contact with me ☐ Yes ☐ No

I give permission for the staff of headspace Rockhampton to obtain relevant information from referrer pertaining to this referral ☐ Yes ☐ No

I understand that headspace Rockhampton will provide the referrer listed on this referral, feedback of the outcome of the referral and intake assessment at headspace Rockhampton. This will only include intake attendance/non-attendance and outcome, not specific content discussed during intake appointment.

Client Signature:		**Date:**	

Referrer's Signature:		**Date:**	

Please fax completed referral and relevant documentation to: 07 4994 2538