headspace Rockhampton Referral Form

On completion of this form, please email to: headspacerocky@roseberry.org.au

For any queries, please contact (07) 4911 6040.

Important information regarding your referral, please read:
• headspace Rockhampton is a short-term **brief intervention** service for young people between the ages of **12 to 25** who are struggling with **mild-moderate** mental health issues. We can offer **6-10 therapy sessions**, depending on a young person's need. • We can only engage with young people who have provided consent to the referral. • **We are not an emergency service.** 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. Once the referral is considered, we will be in touch to either offer an intake appointment or discuss who might be a more appropriate care service to support the young person. • Please provide and attach as much information as possible as it ensures the best quality of care and outcome. • From there, our team will be in touch within **7 days** to let you know the outcome of the referral.

Does the young person know about this referral?	☐ Yes ☐ No – *if no, please gain consent, we can only engage with young people who have provided consent to the referral.*
Is the young person between 12-25 years of age?	☐ Yes ☐ No – *if no, the referral cannot be accepted. Get in touch and we'll talk you through some other options.*

Name of Person Referring:	
Who is referring?	☐ Self ☐ Service Provider ☐ Family/Friend ☐ Other: _____
Name:	
Position / Relationship to Young Person:	
Contact Number:	
Email Address:	

Young Person's Details:					
Name:					
Date of Birth:		**Age:**		**Gender:**	
Address:	**Suburb:**			**Postcode:**	
Contact Number:		**Safe to leave a message?**	☐ Yes ☐ No		
Email (optional)					
Interpreter Required?	☐ Yes, Language: _____ ☐ No				
Assistance with Reading or Writing?	☐ Yes ☐ No				
Do they have a regular GP? If yes, who?					

Parent/Guardian/Next of Kin: We will contact your next of kin in the case of emergency			
Name:			
Relationship:		**Contact Number:**	

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

☐ Short-term brief 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: _____

Presenting Issues:

What's led to the referral to headspace? What are the current concerns?

Is the young person 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)

Any previous mental health support/treatment, counselling, medication or diagnoses?

How does the young person feel about coming to headspace? How motivated are they to come?

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 an intake appointment.

Young Person's Signature:		**Date:**	

Referrer's Signature:		**Date:**	

Please email completed referral form to: headspacerocky@roseberry.org.au

All referrals received are reviewed and actioned within 7 days.