## headspace Hurstville SERVICE PROVIDER REFERRAL FORM

[SELECT DATE]



41 Dora Street, Hurstville NSW 2220 Tel 02 8048 3350 Fax 02 8048 3399 headspace.org.au

Please fax referral to <u>02 8048 3399</u> or email to headspace.hurstville@aftercare.com.au
Please ensure all sections are completed, UPPERCASE and legible.
Our Intake Officers may be contacted during business hours on <u>02 8048 3350.</u>

Please note that we are <u>NOT A CRISIS SERVICE</u>. If crisis assistance is required, please call the NSW
Mental Health Triage on <u>1800 011 511</u>. Alternatively, direct your young person to an accident &
emergency department of their nearest hospital.

Has the Young Person (YP) consented to referral?

Yes

If "NO" referral cannot be accepted.

If the YP is under 16 years & living with parents/carers, are they aware?

YOUNG PERSON'S	S DETAIL S:										
TOUNG PERSON S	DETAILS.										
First Name:				Surnam	ne:						
Preferred Name:											
DOB:				Age:		Gender	:				
Street Address:											
Suburb:						Post Co	ode:				
Home Phone:						Can We	e Leave	a Ms	sg:		
Mobile:						Can Wo	e Leave	a Ms	sg:		
Email:						•					
Can we post letters	to the above a	ddress	;?			YES		NO		UNKNOWN	
[MANDATORY FIE	LD] NEXT OF	KIN (N	IOK) DETA	AILS: mu	st be a	respons	sible ac	dult >	18yo.		
Name:											
Relationship:											
Street Address:	As Above										
Suburb:						Post Co	ode:				
Phone:				Mobile:				•			
Can we contact NOK?					Yes		Emergency Only				

Name of referrer:  Relationship to YP:  Organisation Name:  Street Address:  Suburb:  Phone:  Email:  Would you like to attend the initial appointment?  YES NO UNKNOWN  TOUNG PERSON'S MEDICAL INFORMATION  Does the YP have their own GP?  Details (name, practice, address, phone):  Has the YP ever received prior Mental Health care or has had yES NO UNKNOWN  other workers involved in their care?  Details (please list service & duration):  Does the YP have a Mental Health Care Plan (MHTP)? PLEASE YES NO UNKNOWN  ATTACH A COPY if possible. Tick if Attached □  Date:  Medicare Card?  YES NO Number/Other?  YOUNG PERSON'S CULTURE:  Aboriginal Torres Strait Islander Both Neither Not Stated Refugee  Family of origin/nationality:  Country of Birth? Arrival to Australia?  Language spoken at home?  Risk of homelessness? YES NO  REFERRAL DETAILS:  What is the CURRENT concern regarding this young person?	REFERRER'S DETAIL	.S:											
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REFERRAL DETAILS:	Language spoken at ho	ome?				•							
	Risk of homelessness?	)	YES		NO								
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What is the CURRENT concern regarding this young person?	REFERRAL DETAILS:												
	What is the CURRENT	concern	regarding th	is young perso	on?								

What does the <u>YOUNG PERSON</u> see as the current concern?
Duration of the current problem:
[MANDATORY FIELD] Current Risk Taking (suicide, self-harm, homicide, risk taking behaviours, drug & alcohol
as well as any relevant history or past attempts):
Further details relevant to presenting problem. Please include: lives with, mood, appetite, sleep, home
environment, education/employment, relationships.
What assistance would you like from headspace Hurstville? Please be SPECIFIC.
What assistance would you like from headspace Fluistville: Flease be 31 Lon 10.
The referrer agrees that all information submitted in this referral is an accurate reflection of the client's
support needs, is correct with no information withheld for the organization to fulfil its duty of care to
clients, staff and other partner agencies.
Referrer signature: Date:
ואסוסווסו אועוומנעוד. באועוומנעוד. באועוומנעוד באועומנעוד באועוומנעוד באועוומנעוד באועוומנעוד באועוומנעוד באועוומנעוד באועומנעוד באועוומנעוד באועומנעוד באועומנעו באועומנעוד באועומנעוע באועומנעוד באועומנעוד באועומנעוד באועומנעוד באועומנעוד באועומנעוד באועומנעוד באיר באועומנעונעוד באועומנעונע באיר באירי באועומנעונע באירי באיר באירי באיר באיר באיר באיר בא
NB: headspace aim to contact you regarding this referral within 3 working days.  If you have not heard from us, PLEASE call us ASAP.