

**Agencies/Service Provider Referral form**

Please form to fax: **(02) 9193 8089** or email to: headspaceintake@newhorizons.net.au

**Our intake worker may be contacted during business hours on (02) 9193 8000**

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| Please note that we are not an emergency service or Crisis Service. If you require immediate assistance please call the mental health care line on **1800 011 511**. Alternatively, direct your young person to the Emergency Department of their nearest hospital.**All referrals are reviewed at our intake meeting to determine appropriateness for headspace. We will be in touch within 2 business days: to either offer an appointment, to gather more information regarding the nature and purpose of your referral or to discuss other services who may be more appropriate.** |

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| **Referrer’s details** |
| Name: |  |
| Position: |       | Date: |       |
| Organisation/school: |       |
| Email: |       |
| Contact no: |  | Fax: |       |
| **Consent** |
| Has the young person consented to referral? (If no, the referral cannot be accepted)[ ] Yes [ ] No | If the young YP is under 16 years, are the parents/carers aware? (If no, the referral cannot be accepted)[ ] Yes [ ] No |

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| **Young person’s details**  |
| Surname: |  |
| Given names: |  |
| Preferred name: |   |
| Date of birth:  |  | Age: |  |
| Contact No.  |  | SMS consent: | **[ ]** Yes [ ] No |
| Email: |  |  |  |
| **Does the young person consent to email communication about the service provided through headspace Ashfield? [ ] Yes [ ] No If under 16 is parental consent given? [ ] Yes [ ] No**  |
| Gender: | [ ] Male **[ ]** Female  **[ ]** Other  |
| Medicare card # |  | Reference # |  |
| **Home/Living** |
| Street Address: |  | Suburb: |  |
| State: |  | Post code: |  |
| Where is the YP living: | [ ] At home with family/guardian [ ] Shared accommodation[ ] Staying with friends[ ] Living alone[ ] Med-long term supported accommodation[ ] Refuge/crisis accommodation[ ] Other: |
| **Emergency contact** |
| Full Name: |  |
| Relationship: |  | Consent to be contacted other than in an emergency? [ ] Yes [ ] No |
| Contact No. |  |

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| Are other workers involved with YP’s care? If so, please list and detail the nature of the relationship. (GP, Psychiatrist, FACS etc)  |       |

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| School/TAFE/Uni attending: |  | Current year or highest level achieved: | [ ] <Year 10 [ ] Year 11[ ] Year 12 [ ] Tertiary |
| Employment status: |  |
| Is this YP of the following background? | [ ] Aboriginal [ ] Torres Strait Islander [ ] Both [ ]  Unknown [ ]  Neither |
| Country of birth? |  | Level of English proficiency: | [ ] Very well [ ] Well [ ] Not well [ ] Not at all |
| What culture(s) does YP identify with? (e.g. Chinese, Arabic, Pacific Islander, Australian, New Zealander):  |
| Any special need requirements to be aware of? eg vision impaired, hearing impaired, cognitive impairment Interpreter required?Language: |

**Reason(s) for referral:**

[ ] Homeless or at risk of homelessness [ ] Pregnancy/ Young parent **[ ]** Mental Health

[ ]  Relationships [ ]  Family issues [ ]  School issues [ ] Gender/ sexuality [ ] Trauma/Domestic Violence [ ] Physical/Sexual Health [ ] Behavioural concern

[ ] Alcohol and drugs (please specify): [ ]  Work and Education Options

[ ] Other (please specify):

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| **Details of issue(s). (Please provide as much detail as possible – include any previous diagnoses, treatment(s), risks and some information about presenting issues)** |
| **1. What is the presenting issue/main reason for this referral?****2. Precipitating Factors/ Risk factors?** **3. Is the YP at risk of harming themselves or others?** **Details of Risk/History of Harm:**  **4. Are there any other contributing issues of concern?***(e.g. Legal, Family, School, Housing)* **5. Has the YP ever received prior mental health care?****Reason for previous care:** **Name and contact details of service if known:****Are there any diagnoses, treatments, medications or hospital admissions?****Details:****6. What current supports in place or other services involved?**  |

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| **Office use only** |

Date of referral:

Appointment:

Referred by/ Referral Method:

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| Intake clinician: |  |
| Attended Headspace before and when? |  |
| Mastercare? | [ ] Yes [ ] No | Spread sheet completed? | [ ] Yes [ ] No |
| YP entered into HAPI? | [ ] Yes [ ] No |