Referral Form

Once completed, please return to reception or email to:
hs.dubbo@marathonhealth.com.au

Date: ___/____/_____

☐ Self-Referral (Young Person) ☐ Family & Friends Referral ☐ Returning Client

*If GP or other health service wants to make a referral, please complete the Referral Form – External Providers

headspace is a voluntary early intervention and prevention service. If you (or the young person) are at current risk of harm to yourself or to someone else, please either contact the Mental Health Line on 1800 011 511 (24 hours) for appropriate services, or go to your nearest hospital or call 000.

Referrer's details (if family member or friend is making the referral)

Referrer's Name: _____ Relationship to young person: _____

Referrer's Contact Number: _____

☐ Is the young person aware you are contacting headspace?

☐ Does the young person consent to the referral and headspace contacting them?

(If no, the referral cannot proceed)

☐ If the young person is <16 years of age, has a parent or legal guardian provided consent for the referral to take place?
If so, what is their name and contact number: _____

(if no, the referral may not be able to proceed – please contact us to discuss on (02) 5852 1900)

Young Person's Details

Name: _____ Gender:_____

Date of Birth: ____/____/_____ Age: _____ Pronouns: _____

Best Contact No.: _____ This number is for: ☐ YP ☐Other: _____

Can we send you SMS Reminders: ☐ Yes ☐ No

Home Address: _____

Postal Address (If different from above):_____

Can we send mail to this address: ☐ Yes ☐ No

Email: _____ This email is for: ☐ YP ☐Other: _____

Can we send you emails: ☐ Yes ☐ No

Demographic's

Does the young person Identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Non-Indigenous

Does the young person identify as culturally and linguistically diverse? ☐ Yes ☐ No

If yes, what language: _____

Is an Interpreter required? ☐ Yes ☐ No

Reason for Contact

Current Concerns/ What would you like from headspace?

_____

_____

_____

_____

Safety

Have you (young person) had any thoughts of hurting yourself? ☐ Yes ☐ No ☐ Unsure

Have you (young person) had any thoughts of suicide? ☐ Yes ☐ No ☐ Unsure

Have you (young person) had any thoughts of harming others? ☐ Yes ☐ No ☐ Unsure

If yes, when the was the last time you (young person) had these thoughts:_____

_____

_____

_____

Are you (young person) experiencing domestic or family violence? ☐ Yes ☐ No ☐ Unsure

Do you (young person) currently have a mental health treatment plan? ☐ Yes ☐ No ☐ Unsure

Emergency Contact Person

Please provide the contact details for someone who you would feel comfortable with us contacting in the event of any concerns for your safety or wellbeing.

Name: _____ Contact No: _____

Relationship to you (or young person): _____

headspace use only

Appointment booked with: _____ Date: _____ Time: _____

Form collected by: _____

Suicide risk Identified (SRI) noted in file title: ☐ Yes ☐ No ☐ N/A

Escalated to Clinical Lead if SRI noted or any safety questions marked as 'Yes': ☐ Yes ☐ No ☐ N/A

Mastercare file created? ☐ Yes

hAPI profile created? ☐ Yes

SMS sent to client (or appointment card provided) with

appointment day, time, YCC, centre contact number and MHL: ☐ Yes ☐ No ☐ N/A

Clear Form