

**Agencies/Service Provider Referral form**

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