# Referral Form

## To be completed by services wishing to refer a young person to headspace Bairnsdale.

### Referral Criteria and Guidance

headspace Bairnsdale is a free, youth-friendly and confidential service available to young people aged 12-25 years, in Bairnsdale and surrounding areas. The services available at headspace Bairnsdale include:

* Counselling
* Child and adolescent psychiatrist appointments for young people receiving counselling services from headspace
* Alcohol and drug workers
* Employment assistance
* Centrelink appointments
* Therapeutic and support groups

headspace Bairnsdale works with young people experiencing mild to moderate mental health issues such as stress, anxiety, depression or grief.

headspace Bairnsdale is not an acute mental health / crisis service. If you have any immediate concerns regarding the safety of a young person, please call:

* Kids Helpline: 1800 551 800
* Emergency Services: 000
* Lifeline: 13 11 14

Please return the completed referral form to:

|  |  |
| --- | --- |
| headspace Bairnsdale | Phone: (03) 5141 6200 |
| PO Box 677 or | Email: [referrals@headspacebairnsdale.org.au](mailto:referrals@headspacebairnsdale.org.au) |
| Bairnsdale, Victoria 3875 |  |

### Self-Referral

Young people can refer themselves to headspace Bairnsdale. Young people are encouraged to contact headspace Bairnsdale directly by either phoning, emailing or walk-in to the centre.

### Family and Friend Referral

Family, carers and friends can refer a young person to headspace Bairnsdale. Please contact headspace Bairnsdale directly by either phoning, emailing or walking in to the centre.

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| --- | --- |
| Young Person’s Details | |
| Has the young person consented to this referral?  Yes  No | |
| Name |  |
| Address |  |
| ­Date of Birth |  |
| Phone Number |  |
| Gender | Female  Male  Transgender  Other: |
| Cultural Identity | Aboriginal or Torres Strait Islander  CALD |

|  |  |
| --- | --- |
| Referring Service Details | |
| Date of Referral |  |
| Name |  |
| Address |  |
| Organisation |  |
| Position in Organisation |  |
| Phone Number |  |
| Email |  |

|  |  |
| --- | --- |
| Details of Suport People | |
| Young Person has consented to the following people to be contacted by headspace to support appointments.  Yes  No | |  |
|  |
| Name | **Relationship**  **to Young Person** |  |
| Phone Number | **Email** |  |
| Name | **Relationship**  **to Young Person** |  |
| Phone Number | **Email** |  |
| Name | **Relationship**  **to Young Person** |  |
| Phone Number | **Email** |  |

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| --- | --- | --- | --- |
| Reason for Referral | | | |
| Please include any information which may be useful to assist with the referral (e.g. mental health, drug and alcohol, vocational / educational or physical health including past / current risk assessments). | | | |
| Does the young person:   * have an existing GP? | Yes | No | Unsure |
| If yes, please detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| * have an existing Mental Health Treatment Plan? | Yes | No | Unsure |
| * require an interpreter? | Yes | No | Unsure |

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| Risks to Worker Safety |
| Please include any known risks and current management strategies: |
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