

SERVICE PROVIDER REFERRAL FORM

Please ensure all sections are completed and legible

Once completed, please send to Senior Intake Clinician at headspace Camperdown via one of the following methods:

Fax: 9351 0946

Email: headspace.camperdown@sydney.edu.au

Post: Level 2, 97 Church Street CAMPERDOWN 2050



headspace
Central Sydney

Level 2, 97 Church Street, Camperdown NSW 2050
Tel 02 9114 4100 Fax 02 9351 0946
headspace.org.au

Young person's details

- Surname: _____ • First name: _____
- Gender: _____ • Date of birth: _____
- Address: _____
- Suburb: _____ • Post code: _____
- Home phone: _____ Can we leave a message? Yes No • Mobile: _____ Can we leave a message? Yes No
- Indigenous Identity: Aboriginal Torres Strait Islander Both Neither
- Young persons GP: _____
- Does the young person have a mental health care plan from their GP? Yes Date: _____ No
- Does the young person have a pre-existing diagnosis? Yes No Medication: Yes No

If so, please provide details: _____

- Other services involved in past or current: _____
- Is the young person aware of the referral & wants treatment? Yes No

Referral Source

- Name of referrer: _____ • Relationship to young person: _____
- Organisation name: _____
- Address: _____ • Suburb: _____ • Post code: _____
- Email: _____ Contact number: _____

Consent

- Has the young person consented to and provided permission for the referral: Yes No
- I, _____ DOB: _____ residing at (Address) _____
- _____ give permission for the following/above organisation to exchange information with headspace concerning information related to my involvement in the program
- Sign _____ Signed by: Young person by parent/carer

Next of Kin details

- Next of Kin name: _____ Phone: _____
- Address: _____
- Can we contact next of kin? Yes No, unless in emergency If young person is not contactable

Presenting Problems

Please summarise and attach further info

- What is the main concern regarding this young person?

- What does the young person see as the problem?

- Duration of the current problem

- Home and environment

- Education and employment

- Daily Activities

- Drug and Alcohol Use

- Relationships and sexuality

- Behaviour or Conduct difficulties

- Depression, Anxiety and Eating

- Risk taking and assessment *(please include Suicidality/past attempts/ Homicidal ideation/ deliberate self harm and risk taking.*

• **Psychosis/Mania**

• **What assistance would you like from headspace?**

• **Mental State Examination**

Appearance and General Behaviour □ Other:	<input type="checkbox"/> Normal	Mood (Depressed/Labile) □ Other:	<input type="checkbox"/> Normal
Thinking (Content/Rate/Disturbances) □ Other:	<input type="checkbox"/> Normal	Affect (Flat/blunted) □ Other:	<input type="checkbox"/> Normal
Perception (Hallucinations etc.) □ Other:	<input type="checkbox"/> Normal	Sleep (Initial Insomnia/Early Morning Wakening) □ Other:	<input type="checkbox"/> Normal
Cognition (Level of Consciousness/Delirium/Intelligence) □ Other:	<input type="checkbox"/> Normal	Appetite (Disturbed Eating Patterns) □ Other:	<input type="checkbox"/> Normal
Attention/Concentration □ Other:	<input type="checkbox"/> Normal	Motivation/Energy □ Other:	<input type="checkbox"/> Normal
Memory (Short and Long Term) □ Other:	<input type="checkbox"/> Normal	Judgement (Ability to make rational decisions) □ Other:	<input type="checkbox"/> Normal
Insight □ Other:	<input type="checkbox"/> Normal	Anxiety Symptoms (Physical & Emotional) □ Other:	<input type="checkbox"/> Normal
Orientation (Time/Place/Person) □ Other:	<input type="checkbox"/> Normal	Speech (Volume/Rate/Content) □ Other:	<input type="checkbox"/> Normal

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 is necessary for the organisation to fulfil its duty of care to clients, staff and other partner agencies

Referrer Signature: _____ Date: _____

Please note that headspace does not provide crisis or acute care mental health services. For mental health emergencies contact 1800 011 511