|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Young Person’s Details:** | | | | | | | | | | | | |
| **Name:** | | | | | | **DOB:** | | | | | | **Age:** |
| **Preferred Name (and pronouns):** | | | | | | **Gender:** | | | | | | |
| **Address:** | | | | | | | | | | | | |
| **Postal Address:** | | | | | | **Town/Suburb:** | | | | | | |
| **E-mail:** | | | | | | **Phone:** | | | | | | |
| **Would you like to go on our mailing list to receive newsletters and surveys?** | | | | | | | | | | Yes | | No |
| **Is the young person under 16?** | | | | | | | | | | Yes | | No |
| **If under 16, is the parent/caregiver aware of the referral?** | | | | | | | | | | Yes | | No |
| **Do you identify as Aboriginal and/or Torres Strait Islander?** | | | | | | | | | | Yes | | No |
| **Is English the main language spoken at home?** | | | | | | | | | | Yes | | No |
| **If no, what is the main language?** | | | | | | **Is an interpreter required?** | | | | Yes | | No |
| **Country of birth:** | | | | | **Emergency Contact name:** | | | | | | | |
| **Phone:** | | | | | **Relationship to young person:** | | | | | | | |
| **Referrer Information: (Tick if details are the same as emergency contact)** | | | | | | | | | | | | |
| **Name:** | | | | | **Phone Number:** | | | | | | | |
| **Role & Organisation:** | | | | | **Relationship to young person:** | | | | | | | |
| **E-mail:** | | | | | | | | | | | | |
| **Appointments: (Tick all that apply)** | | | | | | | | | | | | |
| **Preferred appointment method:** | | | In person | | | Phone | | Digital | | | | |
| **Who should be contacted to make appointments?** | | | Young person | | | Referrer | | Emergency Contact | | | | |
| **Do you consent to receive your pre-appointment survey via text message?** | | | | | | | | | | Yes | | No |
| **Does the young person have a Mental Health Treatment Plan?** | | | | | | | | | | Yes | | No |
| **Consent:** | | | | | | | | | | | | |
| *If the young person is under 16 years of age, a parent/guardian must provide consent.* | | | | | | | | | | | | |
| Do you consent for headspace to add the young person to our database? | | | | | | | | | Yes | | No | |
| **Consent type:** | Verbal | Written | | **Name of person consenting:** | | | | | | | | |
| **Young person signature:** | | | | | | | **Date:** | | | | | |
| **Parent/Guardian signature:** | | | | | | | **Date:** | | | | | |
| **Referrer signature:** | | | | | | | **Date:** | | | | | |

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| **Reasons for Referral:** |

**What are the main reasons for this referral?**

**How long has this been going on?**

**How is this impacting your/the young person’s daily life?**

**Have you/the young person accessed any mental health services before? (Please include any formal diagnosis).**

|  |
| --- |
| **Risk Factors:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Suicide** | No | Thoughts | Plan | Intent |
| ***Details:*** | | | | |
| **Self-Harm** | No | Past | Current | Unknown |
| ***Details:*** | | | | |
| **Harm to others** | No | Yes | Unknown | |
| ***Details:*** | | | | |
| **Other risk factors** (e.g. homelessness, substance abuse, social withdrawal, medication compliance) | | | | |
| ***Details:*** | | | | |