Referral Form

Please ensure all sections are completed and legible.

post: *129 High Street, Shepparton 3630 or* ***fax:*** *58218678*

Please Note: This referral is not accepted until an Intake Worker has made contact with the referrer via phone, fax or email. If contact is not made by a worker within three working days please call us on 03 5823 8800.

headspace Shepparton is a voluntary service for young people between the ages of 12 and 25. **headspace** Shepparton can only engage with young people if they have consented to the referral.

Has the young person given consent for the referral? Yes ☐ No ☐

Is the young person aged between 12 and 25? Yes ☐ No ☐

headspace Shepparton is not a crisis service. We are unable to support severe mental health issues or crisis referrals. Please call Goulburn Valley Area Mental Health Services Triage on 1300 369 005 if you have concerns. In an emergency call 000.

If the young person is under 16 years of age are the parents/carers aware of the referral? Yes ☐ No ☐

Details of Young Person

Surname: ______________________ First Name: ______________________

Gender: Male ☐ Female ☐ Other ☐ Date of Birth: ______________________

Address: ______________________

Suburb: ______________________ Postcode: ______________________

Phone (home): ______________________ Phone (mobile): ______________________

Email: ______________________

Which contact/s would the young person prefer us to use? Home ☐ Mobile ☐ Email ☐

Language spoken at home: ______________________

Preferred language: ______________________ Interpreter needed: Yes ☐ No ☐

Indigenous Identity: Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐

Emergency Contact:

Name: ______________________ Relationship to young person: ______________________

Address: ______________________ Suburb: ______________________

Postcode: ______________________ Phone: ______________________

On trial: 30/5/2013

Reasons for Referral

Mental Health ☐ Sexual Health ☐ Drug and Alcohol ☐ Other ☐

Main issue/s:
____
____
____
____
____

Pre-existing diagnosis/relevant past history:
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____
____
____
____

What are your expectations of **headspace** Shepparton?
____
____
____
____
____

Details of Referrer

Relationship to Young Person: ____________________________

Name of Referrer: ____________________________ Organisation: ____________________________

Address: ____________________________ Fax: ____________________________

Phone: ____________________ Mobile: ____________________ Email: ____________________________

Does the young person see any other services at the moment? Yes ☐ No ☐

If yes, please tick appropriate box/boxes:

Drug and Alcohol ☐ School Counsellor ☐ Other Counsellor ☐ Youth Justice ☐

Community Services ☐ Adult Mental Health ☐ CYMHS (Child & Youth Mental Health Services) ☐

Other (please specify): ____________________________

Does the young person have a regular GP? Yes ☐ No ☐

If yes: Name of GP: ____________________________ Contact number of GP: ____________________________

Will your service continue working with the young person? Yes ☐ No ☐

Name of service provider: ____________________________ Contact number: ____________________________