**Eligibility Criteria:**

* **Referral from Service Providers; it is preferred that all relevant collateral information is shared** *(including any assessments, discharge summaries, care plans, action plans & recovery documents)* prior to the referral being reviewed.
* All young people referred will be reviewed by the Clinical Team during Case Review to assess eligibility and suitability for headspace Woolloongabba.
* headspace Woolloongabba works **under Medicare Billing Model (MBS) and ATAPS. Note: Due to demand management placed by Metro South Medicare Local headspace Woolloongabba has restricted access to ATAPS General and SPS until June 2016. With only eligible referrals being for Aboriginal Torres Strait Islander young people; or if a young person has their own community GP that is an ATAPS provider with Metro South Medicare Local the young person may then be able to be allocated sessions under ATAPS and eligible for service at headspace Woolloongabba.**
* For young people that have had a recent suicide attempt and or self harming event and have been reviewed by their GP and or have been referred by an Emergency Department the young person may be referred to **ATAPS Suicide Prevention Scheme, if the young person has their own GP that is an ATAPS provider with Metro South Medicare Local. Otherwise young person is not eligible for service at headspace Woolloongabba; referrers are welcome to contact Clinical Team Leader to further discuss case. If a young person is eligible** they will have access to unlimited sessions for 2 months with a Private Practitioner.
* This means that predominantly young people accessing headspace Woolloongabba are **eligible to 10 Sessions under MBS.**
* A young person will be assigned with a Private Practitioner (Psychologist, Social Worker, Occupational Therapist, Mental Health Nurse) once an Intake and Assessment is completed and their case has been reviewed by the Clinical Team.
* Referrals from **Probation and Parole** require social history, information on convictions and pending legal matters including dates, prior to referral being reviewed.

1. **Referrer (Individual completing this document)**

**Contact Name:** Click here to enter text.

**Position / Relationship:** Click here to enter text.

**Organisation (if applicable):** Click here to enter text.

**Postal Address:**  Click here to enter text. **Post Code:** Click here to enter text.

**Phone:** Click here to enter text. **Mobile:** ­ Click here to enter text. **Fax:** Click here to enter text.

**Email:** Click here to enter text.

**Signed:** \_\_

1. **Young Person Being Referred (these details will be used to contact the young person /parent, guardian)**

**First Name:** Click here to enter text. **Surname:** Click here to enter text.

**Date of Birth:** Click here to enter text. **Age:** Click here to enter text. **Gender:**  M  F  Other

**Address:** Click here to enter text.

**Suburb:** Click here to enter text. **Postcode:** Click here to enter text. **State:** Click here to enter text.

**Home Ph**: Click here to enter text. **Mobile:** Click here to enter text.

**If consent provided by young person please provide details of their parent/ guardian:** Click here to enter text.

***Note To Referrer***

***Please provide as much information in this section as possible as it ensures the best quality of care, outcome and if required referral is afforded to the young person being referred.***

**If the young person is experiencing high levels of distress which may result in harm to themselves or others, please refer them directly to their local Emergency Department or a GP for immediate assistance as headspace is not a Crisis Service or equipped to manage these types of emergencies.**

**(Insert here)**

1. **Information About The Young Person**

**(If Applicable) Risk to self or others (Include self-harm/ suicide attempts, violence, threats of violence)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Type of Behavior** | **Reason for Behavior** | **Outcome/ Treatment Provided** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

(If Applicable) Other Agencies / health care providers currently involved with the individuals care: (e.g.: Government, non-Government, GP’s, Psychiatrists, and Community Services)

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Organisation** | **Contact Person** | **Address** | **Phone** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

1. Presenting Issues

Anxiety  Pain Management Issues  Adhd / Add  Refusing School

Family Problems  Financial Difficulty  Difficulty sleeping  Depression

Physical Abuse  Loss of Appetite  Eating Problems  Self Harm

Relationship Issues  Physical disability  Drug Abuse  History of hospitalisation

Harm or threats to others  Sexual Abuse  Intellectually Impaired  Stress

Domestic Violence  Ptsd / Trauma History  Body Image  Suicidal

Emotional Abuse  Social Problems at School  Bullying Others  Pending Legal Matters

Presentation to ED or Hospital Hallucinations and delusions  Crying  Aspergers / Autism

Past or present contact with Child Safety  Other Click here to enter text.

**In the field below, please include the following information:**

* **Relevant assessment information such as *current diagnosis, concerning behavior, truancy, high acuity, involvement with Child Safety, Police or Youth Justice, etc..***
* **Please indicate what the young person hopes to achieve out of counselling with headspace?**

**Click here to enter text.**

1. **Consent Of Young Person Being Referred**

|  |  |
| --- | --- |
| I am aware that this referral is being made. I understand that I can withdraw from this referral or from the referred service at any time.  **Please NOTE: Referrals will not be processed without signed consent.** | |
| **I give permission** for **headspace** Woolloongabba to use my contact details above for future contact with me. | Yes  No |
| **I give permission** for the **staff** of **headspace** Woolloongabba to obtain relevant information from government and non-government agencies, from doctors and other health professionals specifically relevant to my care whilst being a client of **headspace** Woolloongabba. | Yes  No |
| **I give permission** for **headspace** Woolloongabba to contact the referrer and advise once an appointment has been arranged. | Yes  No |

**Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Print Name:** Click here to enter text. **Date:** Click here to enter text.

***If under 18 years of age authorization ideally should be provided by a parent/ guardian.***

**Parent/ Guardian Signed:** **Print Name:** Click here to enter text.**Relationship:** Click here to enter text.

1. thank you for your referral

**Please return this form to headspace Woolloongabba**

182 Logan road, Woolloongabba

Ph 07 3249 2222

Fax 07 3249 2299

Email [Headspace.Woolloongabba@aftercare.com.au](mailto:Headspace.Woolloongabba@aftercare.com.au)

1. What Next?

* On receipt of a referral a member of staff from **headspace** Woolloongabba will contact the service provider to advise of outcome and then if applicable contact the young person to arrange an appointment.
* All initial appointments will be with a **headspace** Woolloongabba Intake and Assessment Officer, this process takes between 1 – 2 hours.