|  |
| --- |
| **Please note criteria for headspace Lithgow to accept this referral:**   1. **Do you believe this young person is at urgent risk of harm to themselves or other people?**   Yes  No  IF YES, **STOP!** If the young person is currently at risk of harm to themselves or to someone else, they are no suitable for headspace services. Please contact the mental health hotline on  1800 011 511 (24 hours) for appropriate services, take them to your nearest hospital, or call 000.   1. **Are you a family member of a young person or a professional making a referral?**   Family  Professional  If you’re a Professional, **STOP!** Please use our referral form for professionals   1. **Is your young person aged between 12 and 25 years of age?**   Yes  No  IF NO**, STOP!** headspace is a youth mental health service and unfortunately cannot accept referrals outside of this age range.   1. **Does your young person know you are contacting us today?**   Yes  No  If NO, **STOP!** Please talk to your young person about them accessing headspace Lithgow. If you need advice on doing this, please contact our receptionist & one of our Youth Care Coordinators will support you. |

**Young person’s information…**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Today’s date:** |  | | | |
| **Young person’s name:** |  | | | |
| **Age:** |  | | **DoB:** |  |
| **Gender:** |  | | **Pronouns:** |  |
| **Indigenous/Cultural Identity:** | Aboriginal  Torres Strait Islander  Both  non-Indigenous  Other: | | | |
| **Young person’s Residential Address:** |  | | | |
| **Who with?** | At home with family  Living alone  Homeless  Staying with friends  supported accommodation  Refugee | | | |
| **Language other than English spoken at home?** |  | | **Interpreter needed?** | Yes No |
| **On a scale of 1 – 10, how would you rate the young person’s reading & writing skills?**  With **1** being unable to read & write, and **10** superior reading & writing skills | | | |  |
| **Young person’s mobile number:** |  | **Young person’s home number:** | |  |
| **Young person’s email:** |  | | | |

**Your information…**

|  |  |
| --- | --- |
| **Your name:** |  |
| **Your relationship to the young person:** |  |
| **Your phone number:** |  |
| **Your Email Address:**  **Can we send you emails/some resources?** Yes  No |  |
| **What supports do you need to support your young person:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **What services would you like your young person to access?** *Please circle* | | | |
| Mental health wellbeing  headspace services  Youth+ services | Alcohol & another drug support | Physical and/or sexual health support | Work and Study support |
| (Yes / No / Unsure) | (Yes / No / Unsure) | (Yes / No / Unsure) | (Yes / No / Unsure) |

|  |  |
| --- | --- |
| **What do you hope headspace Lithgow can support you with?**  **What do you feel would be useful about your young person coming to headspace?** |  |
| **Is your young person at risk of hurting/harming themselves or others?**  EG: Thoughts of suicide, self-harm, risk-taking behaviours, harming others | No  Yes – can you tell us anymore? |

**Additional details….**

|  |  |
| --- | --- |
| **Are there any current family or court orders?**  *If yes can a copy please be provided***.** | yes  no |
| **Does your young person have a GP?** Doctors name:  Medical centre / Practice: |  |
| Is there a current Mental Health Treatment Plan? | yes  no |
| Does your young person have a NDIS plan? | yes  no |
| **Any other workers/services involved?** |  |
| Best person to contact about this referral: | Young person  You |
| When would be the best time to contact this person? |  |