**headspace Cannington**

**Service Provider Referral Form**

Please ensure all sections are completed and legible.

Return via email [referrals@headspacecannington.com.au](mailto:referrals@headspacecannington.com.au) or fax: **(08) 8432 1668**

Once a referral form has been received, a Triage Officer will contact you within 3-5 working days. Please note that receipt of the referral does not indicate acceptance to the headspace service. The suitability of the referral will be determined following review by our team. Please call to ensure your referral has been received and to discuss anything further. We are happy for you to make contact and discuss service options as sometimes our services are not always the best option for a young person or family. If you have any queries about your referral, please contact us on **08 9358 9800**

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| **headspace Referral Criteria:**  headspace is a voluntary service for young people aged between 12 and 25. We can only connect with Young People if they have consented to the referral and are in this age group.  **Is the Young Person aged 12 to 25?** Yes No  **Has the Young Person consented to this referral?** Yes  No  **If under 16 years, is a parent/guardian aware of the referral?** Yes  No  **These are some of the considerations to determine suitability for a referral:**  - Young Person is presenting with mild to moderate symptoms  - seeking short term early intervention  - Is not at immediate risk of harm to self or others  **If a Young Person requires urgent assistance, please note:**  headspace Cannington is NOT an acute mental health service. We are unable to support severe mental health concerns or crisis referrals. We suggest you please call the Mental Health Emergency Response Line on 1300 555 788 if the Young Person requires urgent mental health assistance. Alternatively, direct the Young Person to the Emergency Department of their nearest hospital or call 000. |

*Please complete this form with as much information as possible and provide any supporting clinical documentation available as this will assist our team in our assessment and determining suitability. If the referral does not have adequate information, please be aware that we may need to contact you for further information prior to proceeding with the referral.*

**1. YOUNG PERSON’S DETAILS:**

Name: Click or tap here to enter text.

Gender: Click or tap here to enter text. Preferred Pronoun(s): Click or tap here to enter text.

Date of Birth: Click or tap here to enter text.

Contact Number: Click or tap here to enter text.

Email Address:Click or tap here to enter text.

Address: Click or tap here to enter text.

Suburb: Click or tap here to enter text.Postcode:Click or tap here to enter text.

Cultural Identity:Click or tap here to enter text.

Language Spoken at home: Click or tap here to enter text.

Indigenous Identity: Aboriginal  Torres Strait Islander  Both Neither

Preferred Language: Click or tap here to enter text. Interpreter needed: Yes No

Medicare Card Number: Click or tap here to enter text. Reference Number: Click or tap here to enter text.Expiry Date: Click or tap here to enter text.

**2. PARENT/GUARDIAN/CARER (EMERGENCY CONTACT):**

Name: Click or tap here to enter text.

Relationship to Young Person: Click or tap here to enter text.

Contact Number: Click or tap here to enter text.

Do we have permission to speak the person identified? Yes No

**3. REASON(S) FOR REFERRAL:**

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| **This section must be completed.**  Please attach any relevant assessment notes, discharge summaries, and/or information. |
| **Primary reason(s) for Referral:**  Mental Health Support: Brief 1-3 sessions Focused Psychological Intervention  Alcohol and Other Drug Support Physical Health Support  Vocation or Education Support Groups |
| **Current Presenting Issues:**  Click or tap here to enter text. |

**Please provide details of any diagnoses and treatment:**

Does the Young Person have any pre-existing diagnoses? Yes  No

Has the Young Person received previous treatment? Yes No

Does the Young Person have a Mental Health Care Plan (MHCP)? Yes \* No

If yes, please attach the referral letter and MHCP

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| **\* Please provide details of diagnoses and previous intervention:**  Click or tap here to enter text. |

**4. SAFETY CONSIDERATIONS**

**Suicidal?** Yes ***(Thoughts Plan Intent)*** No Active Safety Plan (Please attach)

Details: Click or tap here to enter text.

**Harming self?** Yes No Active Safety Plan (Please attach)

Details: Click or tap here to enter text.

**Past physical or verbal aggression?** Yes No

Details: Click or tap here to enter text.

**Substance use?** Yes No

Details: Cocaine MDMA Cannabis Cigarettes Alcohol

Other: Click or tap here to enter text.

**Homelessness?** Yes No

Details: Click or tap here to enter text.

**School avoidance?** Yes No

Details: Click or tap here to enter text.

**Extreme social withdrawal?** Yes No

Details: Click or tap here to enter text.

**Other:** Click or tap here to enter text.

**5. REFERRER DETAILS**

Name of Referrer: Click or tap here to enter text.Date: Click or tap to enter a date.

Service/Organisation: Click or tap here to enter text.

Service Provided: Click or tap here to enter text.

Contact Number: Click or tap here to enter text.Fax: Click or tap here to enter text.

Email: Click or tap here to enter text.

Service Address: Click or tap here to enter text.