headspace Castle Hill
Service Provider Referral Form

Please ensure all sections are completed and legible.
Return via email **headspace.castlehill@flourishaustralia.org.au** or fax: **02 8331 6055**

Once a referral form has been received, a Youth Access Team Clinician will make contact with you within 3 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 **02 9393 9800**.

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 early intervention support
- Requires approximately 12 months of treatment
- Is not at immediate risk of harm to self or others

If a Young Person requires urgent assistance please note:
headspace Castle Hill 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 Line on 1800 011 511 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.

We are constantly working on improving our service to young people and would appreciate your feedback. We'd love to hear about your experience through our quick survey:
https://www.surveymonkey.com/r/P2JF8YH

1. YOUNG PERSON'S DETAILS:

Name: _____

Gender: _____ Preferred Pronoun(s): _____

Date of Birth: _____

Contact Number: _____

Email Address: _____

Address: _____

Suburb: _____ Postcode: _____

Cultural Identity: _____ Language Spoken at home: _____

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

Preferred Language: _____ Interpreter needed: Yes ☐ No ☐

Medicare Card Number: _____ Reference Number: _____ Expiry Date: _____

2. PARENT/GUARDIAN/CARER: *

Name: _____

Relationship to Young Person: _____

Contact Number: _____

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

**** If the young person is aged 15 and under, we will require a parent or guardian***

3. REASON(S) FOR REFERRAL:

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:

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

Please provide details of diagnoses and previous intervention:

4. SAFETY CONSIDERATIONS

Suicidal? Yes ☐ * No ☐ * Thoughts ☐ Plan ☐ Intent ☐

Details: _____

Harming self? Yes ☐ No ☐

Details: _____

Past physical or verbal aggression? Yes ☐ No ☐

Details: _____

Substance use? Yes ☐ No ☐

Details: Cocaine ☐ MDMA ☐ Cannabis ☐ Cigarettes ☐ Alcohol ☐ Other: _____

Homelessness? Yes ☐ No ☐

Details: _____

School avoidance? Yes ☐ No ☐

Details: _____

Extreme social withdrawal? Yes ☐ No ☐

Details: _____

Other: _____

5. REFERRER DETAILS

Name of Referrer: _____ Date: _____

Service/Organisation: _____

Contact Number: _____ Fax: _____

Email: _____

Service Address: _____

Do you wish to be part of our mailing list? Yes ☐ No ☐