External Services - Referral Form

Once completed, please return to reception or email to:

hs.dubbo@marathonhealth.com.au

Date: ____ /____ /_____ Returning Client: ☐ Yes ☐ No

--If a Young Person, Family or Friend wants to make a referral, please complete the Self-Referral Form--

headspace is a voluntary early intervention and prevention service. If the young person is currently at risk of harm to themselves or to someone else, they are not suitable for headspace services. Please either contact the Mental Health Line - 1800 011 511 (24 hours) for appropriate services, or go to your nearest hospital or call 000

Does the young person (YP) consent to this referral? ☐ Yes ☐ No

Is the YP between the age of 12 and 25 years of age? ☐ Yes ☐ No

If under 16 years, are the parents/care givers aware and providing consent for the referral to take place? ☐ Yes ☐ No

If no, please call us on (02) 5852 1900 as we may not be able to accept the referral but can talk you through some other options

Who is the best person to contact about this referral? ☐ YP ☐ Other: _____

Contact: _____

Young Person's Details

Name: _____ Gender: _____ Pronouns: _____

Preferred Name: _____ Date of Birth: ____ /____ /____ Age: _____

Best Contact Number: _____ This number is for: ☐ YP ☐ Other: _____

Residential Status:

☐ At home with family ☐ Living alone

☐ Staying with Partner ☐ Homeless

☐ Refuge ☐ Supported accommodation

Address: _____

Can we send mail to this address? ☐ Yes ☐ No; Postal Address: _____

Email: This email is for: ☐ YP ☐ Other:

Parent/ Legal Guardian name (if under 16): _____ Phone Number: _____

Emergency Contact Name: _____ Contact Number: _____

Relationship to young person: _____

Demographics

The young person identifies as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Non-Indigenous?

Does the young person identify as culturally and linguistically diverse? ☐ Yes ☐ No

If yes, what language: _____

Is an Interpreter required? ☐ Yes ☐ No

headspace National Youth Mental Health Foundation is funded by the Australian Government Department of Health under the Youth Mental Health Initiative

ABN 86 154 318 975

Referral Details

What has led to this referral to headspace? What are the current concerns?

Are there any indicators of risk or harm?

Thoughts of Suicide	☐ Yes	☐ No
Self-harm	☐ Yes	☐ No
Harm to others	☐ Yes	☐ No
Substance abuse	☐ Yes	☐ No
Domestic Violence	☐ Yes	☐ No

Details of Risk

Is there anything else happening that might be affecting the YP? (e.g. Family issues, exam stress, issues with friends or relationships)

Is there anything from the past that might be affecting the YP now?

Any previous mental health support/treatment, counselling, medication or diagnoses?

What does the YP feel would be useful about coming to headspace, what are their goals? How motivated are they to come?

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Any other information that may be relevant? (e.g. family history of mental health issues, court involvement, intellectual disability, physical disability)

_____

_____

_____

Additional Information

Does YP have a GP? ☐ Yes (See below) ☐ No

GP name: _____ GP practice: _____

Is there a current Mental Health Treatment Plan? ☐ Yes ☐ No

Does the YP have an NDIS plan? ☐ Yes ☐ No

Any other workers/services involved?

Name: _____ Organisation/Position: _____

Email: _____ Contact Number: _____

Referrer details

Name: _____ Organisation/Position: _____

Email: _____ Contact Number: _____

Referrer Signature: _____ Date: ____ / ____ / _____

headspace use only

Appointment booked with: _____ Date: ____ / ____ / _____ Time: _____

Form collected by: _____

SRI noted in file title: Yes ☐ No ☐ N/A ☐

Escalated to Clinical Team Lead: Yes ☐ No ☐ N/A ☐

Acknowledgement of referral sent: Yes ☐ No ☐ N/A ☐