**Referral Guidelines**

**About headspace Goulburn**

**headspace** Goulburn is a free, youth-friendly and confidential service for young people aged 12 – 25 years. Lead by Grand Pacific Health, **headspace** Goulburn, brings together a range of services, to provide a holistic “one-stop-shop” for young people. We offer information, intake, assessment support and referral. **At headspace Goulburn** we offer the following supports and services including:

* Mental Health Support – Youth Counsellors, Youth Workers and other Mental Health Professionals
* Drug and Alcohol Support
* Education and Employment Support
* Physical Health and Sexual Health

**PLEASE NOTE:**

**headspace Goulburn is not an acute mental health/crisis service. If you have any immediate concerns regarding the safety/wellbeing of a young person, please call: Mental Health Line 1800 011 511; Lifeline on 13 11 14; or Kids Helpline on 1800 55 1800. In an emergency, contact 000 immediately.**

**HOW TO REFER:**

**Self-Referral**

Young people are encouraged to make contact with the headspace Goulburn service directly.

**By phone/email**

Young people can call (02) 4824 4944 within office hours or email info@headspacegoulburn.org.au, and a worker will contact the young person to complete a referral.

**Drop in**

Young people can call into **headspace** Goulburn, 13-17 Verner Street, Goulburn, between 9am and 5pm, Monday – Wednesday &Friday and Thursday 11am – 7pm. Staff will endeavour to see the young person and will assist them with a referral and an appointment will be made as soon as possible.

**Professional Referral- Service Providers**

GP’s, Allied Health Professionals, community-based agencies and educational institutions can all refer young people to **headspace** Goulburn using the Service Providers Referral Form. General Practitioners should include a mental health care plan (if appropriate) for the young person and attach this to the **headspace** Goulburnreferral form.

**Family Referral**

Families, carers or friends can refer a young person to **headspace** Goulburn. The young person needs to be aware of and consent to the referral and be willing to meet with a member from the **headspace** Goulburn team. Once receipt of referral has been confirmed, a worker will contact the young person to make an appointment. Families, parents or carers who have a young person engaged with **headspace** Goulburn can also access our centre to discuss service provision.

If you are unsure about making the referral please contact headspace for consultation.

For more information regarding **headspace** Goulburn, please contact us directly or visit our website www.headspace.org.au/goulburn

**CONFIDENTIAL**

**headspace Goulburn General Referral Form**

**Date of referral:** \_\_\_\_/\_\_\_\_\_/\_\_\_

**Young Person (Client) Details**

Name Age DOB:

Sex: Male Female Gender Diverse Intersex Indeterminate Other

Address:

Residing with Family? Yes No

Home Ph: Mob Ph:

Email:

Education:\_ Year:

Employed: Fulltime Part-time Unemployed

Place of Employment:

**Other Contact Details**

Next of Kin / Other contact person:

Relationship:

Ph: Mob:

Can we contact this person regarding appointments? Yes No

Can we SMS this person regarding appointment? Yes No

**Referrer Details**

Name: Organisation/Service:

Job Title:

Ph: Fax:

Mob Ph:

Email:

*Is the client aware of the referral and wanting treatment?* Yes No

*Has the client got their own GP?*  Yes No Unsure

*If yes, has a Mental Health Care Plan been created?* Yes No Unsure

**Young Person Specifics**

**Presenting Problem:**

1.

2.

3.

**What does the young person see as the problem?**

**What do you the referrer see as the problem? (What observations have you made that raise your concerns for the client’s mental and emotional wellbeing?).**

**Duration of current problem:** Days Weeks Months Years

**History of Presenting Problem:**

**Relevant background information:**

**Previous Mental Health Treatment (by whom/ dates)**

**Other Services Involved (Previous/Current)**

**Risk (please tick and detail where positive):**

|  |  |  |  |
| --- | --- | --- | --- |
|  Self Harm  |  Suicidality |  Risk to Others |  Other Risk Behaviour |

**What service are you requesting from headspace (circle all that apply)?**

GP Youth Worker Mental Health Clinician Drug/Alcohol Employment/Education

**Other Comments:**