Referral to headspace Services
(Please select ONE and forward to nearest centre)

☐ **Mt Druitt**	☐ **Parramatta**	☐ **Penrith**
Shop 12, Daniel Thomas Plaza 6-10 Mount St, Mt Druitt NSW 2770 ***Phone:*** *(02) 9675 2602* ***Fax:*** *(02) 8887 5610* ***Email:*** *headspacemtdruitt@ucmh.org.au*	2 Wentworth St, Parramatta NSW 2150 ***Phone:*** *(02) 8624 1348* ***Fax:*** *(02) 8624 1388* ***Email:*** *headspaceparramatta@ucmh.org.au*	606 High St, Penrith NSW 2750 ***Phone:*** *(02) 4720 8888* ***Fax:*** *(02) 4720 8844* ***Email:*** *headspacepenrith@ucmh.org.au*

Important information regarding your referral, please read:

- **headspace** is a service for young people between the ages of 12 to 25. We can only engage with young people who have provided consent to the referral. *N.B. If YP is unable to provide informed consent due to mental state (e.g. psychosis), please contact us.*
- If the young person is at high or acute risk of suicide, please contact emergency services on 000.
- Please note that receipt of the referral form does *not* indicate acceptance to the **headspace** services. Suitability of the referral will be determined following assessment with the young person. Please contact the relevant **headspace** site to confirm receipt and discuss the outcome of your referral.
- To complete the referral, you must attach relevant assessment notes, discharge summaries and/or additional information. We will endeavour to respond to referrals within 24 – 48 hours if received during business hours. If you have any queries pertaining to your referral, please phone the relevant site using the contact details above.

Consent for referral: *If YP is unable to provide informed consent due to mental state (e.g. psychosis), please contact us.*

Has the young person consented to and provided permission to exchange information in relation to this referral?	☐ **Yes**	☐ **No**

Primary reason(s) for Referral: This section must be completed. Please contact us for queries regarding services available

☐	Assessment for short-term mental health intervention with **headspace** Primary Care Team Does the YP have a Mental Health Care Plan? ☐ Yes ☐ No		
☐	Assessment with **headspace** Youth Early Psychosis Program (YEPP)		
☐	Drug and Alcohol Support	☐	Vocational Support
☐	Physical Health Support		

Referrer details: headspace will be corresponding with you using the below details. Please ensure that all details listed below are correct and legible

Name of Referrer:		Organisation:	
Relationship to Young Person		Designation:	
Contact Number		Fax:	
Service Address:			
Email:			

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

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Parent/guardian: * please note that if the Young person is aged 15 and under, we will require a parent or guardian to be documented on this form.

Name:

Relationship to young person: Contact Number:

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

Young Person's details:

Name:

Date of Birth: Age: Gender:

Address:

Suburb: Post code:

Contact Number 1: 2.

Medicare Card Details: Expiry Date:

Interpreter Required? ☐ Yes, Language: ☐ No

Assistance with Reading/Writing? ☐ Yes ☐ No

Presenting Issues:

Current presenting issues (please include duration, age of onset, and relevant pre-existing diagnoses):

Impact of problem on functioning: (e.g. relationships/school/home/work)

Please indicate if there is any know family history of mental health conditions:

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Previous/current engagement with other services:

Risk Factors:

☐ Suicide ☐ Non-accidental self-injury ☐ Harm to others ☐ Extreme social withdrawal

☐ Homelessness ☐ Substance use ☐ Accidental Death ☐ Non-compliance

Details:

Referrer's Signature:

By signing this document, the referrer agrees that the above information is a true and accurate.

Date:

Office Use Only

Plan (to be reviewed at intake meeting): ***When booking appointment, please request that the YP attends 15 minutes prior to their appointment time***

□ Book with YAT Clinician Date/Time: _____ Clinician: _____

□ Joint YAT/MATT Consultation Date/Time: _____ Clinician: _____

□ Direct Allocation to CCT Date/Time: _____ Clinician: _____

□ MATT Assessment

□ Referral to Co-located LHD Team Date/Time: _____ Clinician(s): _____

□ Declined/Referred Elsewhere Recommendations Made: _____