Community Referral Form

GPs to complete Mental Health Treatment Plans (MHTP) - not required for hYEPP
For any inquiries, please contact us on **1800 063 267**
Please fax referrals to **headspace** Adelaide on **1800 632 193**

Young Person's Details

Name: _____ DOB: _____
First *Last*

Address: _____
Street Address

_____
City *State* *Post Code*

Is it okay for us to send **headspace** branded documents to this address? YES ☐ NO ☐

Phone: _____ Email: _____

Gender: _____ Preferred pronouns: _____ Medicare No: _____ Exp. ____/____

Next of Kin/Emergency Contact: _____
Name *Phone number*

Does the young person require an interpreter? YES ☐ NO ☐ If yes, which language? _____

Does the young person identify as Aboriginal or Torres Strait Islander? YES ☐ NO ☐

Does the young person have an existing GP? YES ☐ NO ☐ Does the young person have an existing MHTP? YES ☐ NO ☐

Practice Name *(if applicable)*: _____

Doctor's Name *(if applicable)*: _____

Referrer's Details

Name: _____ Phone: _____
First *Last*

Email: _____

Relationship to young person: _____
Organisation (if applicable)

Important information about your referral

headspace is a service for young people aged 12-25.We can only engage with young people who have provided consent to the referral.
If young person is unable to provide informed consent due to mental state (e.g. psychosis), please contact us.

headspace Adelaide is not a crisis service and should you have any concerns, if the young person is in crisis, or if they are at an acute risk of harming themselves or others, please contact emergency services on **000**. In a mental health emergency, please contact Mental Health Triage on **13 14 65**

The receipt of the referral form does ***not*** indicate acceptance to **headspace** Adelaide. Suitability of the referral will be determined following assessment with the young person. Please contact us on 1800 063 267 to confirm receipt and discuss the outcome of your referral.

To provide a complete referral, please attach any relevant assessment notes, discharge summaries and/or additional information. We will endeavour to respond to referrals within 24-48 business hours, but if you have any queries pertaining to our referral, please phone us using the contact details above.

Consent

Does the young person consent to this referral? YES ☐ NO ☐

Office Use Only

Appointment booked: HDSP / MBS / GP / MATT / CCT **Date:** **Time:**

Referred elsewhere (details):

Person completing this form: **SEP18**

The **headspace** Adelaide Primary Platform offers early intervention, short term support for young people experiencing mild to moderate mental health difficulties. Other services include, GPs, Drug & Alcohol Counselling and Vocational and Educational Support programs.

Is this referral for the Primary Platform? ☐

The **headspace** Adelaide Youth Early Psychosis Program (hYEPP) provides a multidisciplinary, early intervention service for young people experiencing, or at risk of developing, a first episode of psychosis.

Is this referral for the Youth Early Psychosis Program? ☐

Reason for Referral

What are some of the current issues? *(please include info about duration, age of onset and pre-existing diagnoses):*

What has been the impact of these? *(e.g. relationships, school, work, home etc.):*

What are the young person's goals and objectives?

Is there any family history of mental health conditions?

Is the young person currently supported by other health services? *(If so, please provide service details below)* YES ☐ NO ☐

Does the young person consent to **headspace** Adelaide exchanging information with these services to support this referral? *(If so, please provide contact details below)* YES ☐ NO ☐

Risk Factors *(referrer to complete)*

	None	Low	Medium	High
Suicide	☐	☐	☐	☐
Non-suicidal self-injury	☐	☐	☐	☐
Harm to Others	☐	☐	☐	☐
Vulnerability	☐	☐	☐	☐

Other risk factors?
(e.g. homelessness, social withdrawal, medication compliance)

Reset

SEP18