**Family/Friends Referral**

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| --- | --- | --- |
| **Date** |  |  |
| **General Information** |
| **First Name** |  | **Last Name** |  |
| **Alias / Skin Name / Preferred Name (i.e. Kuminljai)** |  |
| **DOB** |  | **Gender** | [ ] Female [ ] Male [ ]  Gender Diverse [ ] Indeterminate [ ] Other |
| **Sexuality** | [ ] Heterosexual (Straight) [ ] Lesbian [ ] Gay [ ] Bisexual [ ] Other Sexuality (i.e. Queer, Pansexual, etc.) [ ] Questioning [ ] Choose not to answer |
| **Please specify if ‘Other’:** |  |
| **Relationship Status** | [ ] Single/Never Married [ ] In a relationship/Married/De Facto [ ] Divorced [ ] Separated [ ] Widowed [ ] Choose not to answer |
| **Indigenous?** | [ ] No [ ] Aboriginal [ ] Torres Strait Islander [ ] Aboriginal and Torres Strait Islander [ ] Choose not to answer |
| **Ethnicity (other than Aboriginal and/or Torres Strait Islander)** |  |
| **Country of Birth** |  | **Town of Birth** |  |
| **If not Australian, year of arrival?** |  |
| **Main Language Spoken at Home** |  | **Other Languages** |  |
| **Contact Details** |
| **Address** |  |
| **Town** |  | **State** |  | **Postcode** |  |
| **Mobile Number** |  |
| **Email**  |  |
| **Emergency Contact Details** |
| **Name** |  | **Relationship** |  |
| **Mobile Number** |  |
| **Next of Kin Details (If not the same as Emergency Contact Details)** |
| **Name** |  | **Relationship** |  |
| **Mobile Number** |  |
| **Health Care Card Information** |
| **Medicare Number** |  | **Reference Number** |  | **Expiry** |  |
| **(If applicable) Centrelink Health Care Card Number** |  | **Expiry**  |  |
| **Service Information** |
| **What support would you like to access? (Tick more than one if applicable)** | [ ] Doctor [ ] Psychologist/Mental Health Counselling  [ ] Work/Vocational Support [ ] AOD |
| **Please tick which boxes below apply to you for relevant information relating to why you are accessing our youth service:** |
| [ ] Feeling Sad or Depressed[ ] Feeling Anxious[ ] Concerned Sleeping[ ] Concerned Eating[ ] Self Esteem/Body Image[ ] Relationship Issues[ ] Substance Abuse (Alcohol/Drugs)[ ] Financial Situation | [ ] Sexual Health[ ] Sexuality Confusion/Questioning[ ] Gender Confusion/Questioning[ ] Living Situation[ ] Work and Study[ ] Disruptive Thoughts | [ ] Doctor Check Up[ ] Anger and Aggression[ ] Bullying[ ] Stress[ ] Loneliness[ ] Nightmares |
| **Other:**  |
| **How long has/have this/these been an issue for you?** | [ ] Days (1-6) [ ] Weeks (1-3) [ ] Months (1-11) [ ] Years (1+) [ ] Unsure |

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| **Referrer Information** |
| **Referred by** | [ ] Family Member [ ] Friend [ ] Partner [ ] Carer |
| **Referrer Name:** |  |
| **Relationship:** |  | **Phone** |  |
| **Mobile** |  | **Fax**  |  |
| **Email**  |  |
| **Has the young person previously accessed a headspace centre before?** | [ ] Yes [ ] No [ ] Unsure |
| **Is the young person aware of this referral?** | [ ] Yes [ ] No [ ] Unsure |
| **If under 16, are the parents/carers aware of this referral (and willing to respect and comply with headspace policies)?** | [ ] Yes [ ] No [ ] Unsure |
| **Is the young person under the care of Territory Families or in alternative care arrangements (i.e. living away from home in foster care)?** | [ ] Yes [ ] No [ ] Unsure |
| **Does the young person currently access any other services (e.g. DASA, Anglicare)?** | [ ] Yes [ ] No [ ] Unsure |
| **Please Specify if ‘Yes’:** |  |
| **Does the young person have any previous (or current) Mental Health Treatment Plans (MHTP)?**  | [ ] Yes [ ] No [ ] Unsure |
| **Please Specify Where/Who From if ‘Yes’:** |  |
| **Please provide any relevant information/details of why the young person requires general practitioner, counselling or vocational support below from your understandings:** |
|  |

 **Please return this completed form to our headspace Reception in person or by fax or email.**