headspace client referral and consent form

This form is for young people aged 12-25 years old to fill out, or for family and friends or another service provider to fill out on their behalf, to request support from headspace Alice Springs.
We will respond to your referral within 1 week of receipt.

Email this completed referral form to headspace.reception@caac.org.au
Or call us on 08 8958 4544 or visit us: 5/74 Todd Street, Alice Springs NT 0870

Do you need to speak to someone urgently? If life is in danger call Triple Zero 000
Kids Helpline - call 1800 551 800 - 24/7 crisis support
Lifeline - call 12 11 14 - 24/7 crisis support
Beyond Blue - call 1300 224 636 – 24/7 support
Suicide Call Back Service - call 1300 659 467 – 24/7 support
13YARN on 13 92 76 (24/7) and talk with an Aboriginal or Torres Strait Islander Crisis Supporter

Date form completed _____

Referral Source: Are you completing this request for yourself or on behalf of someone else?

for myself ☐ or are you: Family/Friend ☐ Other Service ☐

1. Young Person's details

First Name: **Last Name** **Preferred name:**	**Date of Birth:**

Address:

Email:

Phone contact:

Gender identity: Female ☐ Male ☐ Gender diverse ☐ self-describe:

Pronouns: She/Her ☐ He/Him ☐ They/Them ☐ self-describe:

Country of birth:

headspace client referral and consent form

Cultural Identity: Aboriginal ☐ Torres Strait Islander ☐ Aboriginal + Torres Strait Islander ☐

Non-Aboriginal ☐ Other cultural identity _____

Language: Which language are you most comfortable speaking in?

Do you require an interpreter? yes☐ no ☐

Sexuality: Do you identify as Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐

other sexuality ☐ Questioning ☐ Prefer not to answer ☐ I don't know what these words mean ☐

Living situation: With family ☐ With flatmates ☐ Alone ☐

No permanent address ☐ Visiting Alice Springs ☐

Would you like to involve a family member or support person in the next steps of connecting with headspace? Yes ☐ No ☐

If yes who?

Medicare number:

Ref:

Expiry Date:

Student: Yes ☐ *where?* No ☐

Employment: Yes ☐ *full time* ☐ *part time* ☐ No ☐

Emergency Contact- *an emergency contact is required*

Name:

Relationship to young person:

Phone contact:

**NB: Clients under 16 years require Parent or Guardian consent.*

headspace client referral and consent form

2. Reasons for seeking support

☐ Mental health and wellbeing ☐ Physical health ☐ Alcohol & drugs

☐ Work or study ☐ Family support ☐ Eating

☐ Sexual health ☐ Social support ☐ Relationships

☐ other _____

Please provide any important information you want us to know below

Risk taking behaviours Have you engaged in self-harm? Have you had suicidal thoughts? Do you use alcohol or other drugs as a way of coping with your feelings?	
Strengths What keeps you strong? What supports do you have?	
Involvement with any agencies/services Have you attended or do you use other services? Please provide details	

headspace client referral and consent form

3. Family/Friend details (for Family/Friend making the referral):

Name	Relationship to young person

Address:

Email:

Telephone contact:

4. Service Provider details (for service provider making the referral):

Name: **Job Title:**

Service: **Phone contact:**

Email:

Does the Young Person have a Mental Health Care Plan? Yes ☐ No ☐

Is the young person aware of the referral? Yes ☐ No ☐

If under 16 years is the parent/guardian aware of the referral? Yes ☐ No ☐

Headspace OFFICE USE ONLY

Referral received by_____

Date:_____

Scanned into headspace Alice Springs system by_____

Date:_____

5. Consent to Service

What information do we collect?

As part of providing support, we will need to collect and record personal information from you that is relevant to your situation. Your personal information will be recorded in a secure database. If you see the GP at headspace we will also need to share your Medicare details so that bulk billing can occur.

Prior to your session you will receive a link to a survey called hAPI, should you not be able to complete this you can use a headspace iPad to complete the survey when you arrive at the centre. This survey asks questions about how you are feeling and what you think about headspace. The worker you see will also complete a survey about your visit. This information is provided to headspace National, but can't be identified as 'you'.

Is my information confidential?

All **headspace** Alice Springs staff are bound by Congress confidentiality rules. This means that they can't talk about you or your personal information outside of work.

However, there are some *exceptions* to this:

- If we believe you are at risk of harming yourself
- You are at risk of harming someone else or at risk of harm by someone else
- If you are or have been abused by someone and are under the age of 18
- Or if your notes are subpoenaed by a Court

We will always try to tell you first if we need to break your confidentiality. If you are under 16, we will also talk to you about what will be discussed with your parent/carer and the extent to which your parent/carer will be involved in your care at headspace Alice Springs.

What information do we share?

The headspace Alice Springs team meet together regularly to discuss how we are working together to provide the best service for you. In this case, the identifying information discussed will be kept to a minimum with respect to yourself.

By signing this form, you give headspace staff including Doctors, Counsellors, Employment and Engagement staff permission to discuss information relating to your-self and co-locating professionals from other agencies.

On occasion, headspace Alice Springs may also have to provide random files for a confidential review by accredited bodies to ensure we are working in line with the National Mental Health Standards; but this will not focus on individual details shared with a staff member.

We will seek your consent before we share information with any other health services, community agencies, family members and/or friends.

If you need clarification on any of these matters, please speak to a staff member.

headspace client referral and consent form

6. Consent signing page

I have read and understood the above information and consent to participate in this service as outlined and understand that I can withdraw my consent at any time.

It has been explained to me that: (Please tick the following)

- ☐ There are some instances where my headspace Alice Springs worker may have to break confidentiality to keep me safe.
- ☐ headspace staff meet regularly to discuss information relating to me in the interest of best care.
- ☐ This is a voluntary service and I can choose to leave and not come back at any time.
- ☐ If I have any worries about the service I receive, I can talk to my worker or contact the manager of headspace Alice Springs.
- ☐ headspace staff will call your emergency contact should we not be able to contact you.
- ☐ Each time I connect with my headspace worker, I will complete a HAPI Survey. The information collected will be used by headspace Alice Springs staff to assist in providing me with the best support possible. This information then becomes anonymous and is shared with the headspace National Office to assist with evaluation and research.

As a young person attending headspace Alice Springs you have a responsibility to:

- ☐ Treat staff and other young people without discrimination
- ☐ Not attend headspace under the influence of alcohol or other drugs
- ☐ Let us know if you are running late or cannot attend an appointment
- ☐ Let us know if you no longer wish to access headspace services

Signature: _____ (Young person)

Print Name: Date:

If young person is under 16, consent should be provided by parent/guardian/carer

Signature: _____ (Parent / Guardian)

Print Name: Date: