headspace Armadale is a free, youth-friendly, confidential service available to young people aged 12 – 25 years, in the South East metropolitan region of Perth. **The mental health services are for mild to moderate (tier 1 and 2) presentations**. headspace Armadale brings together a range of co-located community-based and government agencies, to provide a holistic service as a “one-stop-shop” for young people. We offer information, intake, assessment and referral.

Services available at headspace Armadale include:

|  |  |
| --- | --- |
| * Mental health and emotional support * MBS Psychological service * MBS Social Work service * Counselling | * Drug and alcohol support * Work and study support * Sexual health clinic |

**How to refer**

* Referrals accepted from GP’s, Allied Health Professionals, community-based agencies and educational institutions
* When available, for MBS services include a copy of the client’s Mental Health Care Plan

**Client Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Referral** | **DOB**      /     / | | |
| **Name** | | | |
| **Sex** (assigned at birth) Male   Female  Intersex | | | |
| **Gender Identity**  Male   Female  Gender Diverse | | | |
| **Address** | | | |
| **Email** | | **Mobile** | **Home Phone** |

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| --- |
| **Are there any safety concerns when contacting the patient by phone/mail?** |
| **Consent to contact young person via: (e.g. confirm appointments etc.)**  **Mobile:** Yes  No **Text:**  Yes  No **Voicemail:**  Yes  No  **Email:**   Yes  No **Mail:**  Yes  No **At home:**  Yes  No  **Preferred method of contact *(this can change and other arrangements can be made):*** |

|  |
| --- |
| **Language spoken at home** |
| **Ability to speak English?**  Very well  Well  Not well  Not at all **Preferred Language** |
| **What is the client’s cultural background?** First Nations  CaLD  Unknown Other (please advise) |
| **Who does the young person live with?** |
| **Is the client aware and consented to the referral and wanting treatment?** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Next of Kin (MUST be completed if client is under 16 unless mature minor process followed)** | | | |
| **Next of Kin name** |  | **Mobile number** |  |
| **Relationship to client** |  | **Home number** |  |
| **Is the young person’s parent/guardian aware that this referral has been made?** Yes  No | | | |
|  |  |  |  |

**Reason for Referral**

**PLEASE NOTE: headspace does not provide crisis or acute care, if in crisis please refer to the closest Emergency Department (call 000) or call the Mental Health Emergency Response Line (MHERL) on 1300 555 788**

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| --- | --- | --- | --- | --- |
| **Presenting Issues** *(please include any background information which may be useful to assist with the referral e.g. mental health, drug and alcohol, vocational/educational, physical health, including past/current risk assessments)* | | | | |
| Mental health  Situational  Eating | | Physical health  Vocational/education  Home/environment | Sexual health  Social support  Friendships | Alcohol/drugs  Family support  Relationships/sexuality |
| **Mental health diagnosis** (if relevant) (*Please attach copy of current Mental Health Treatment Plan if available)* | | | | |
|  | | | | |
|  | | | | |
| Duration of presenting problem: | | | | |
| **Risk to self or others** *(include self-harm/suicide attempts, violence, threats of violence, addiction/regular intoxication/AOD influence?)* | | | | |
|  | | | | |
|  | | | | |
| **Medications** (if relevant)**:** |  | | | |
|  | | | | |
|  | | | | |
| **Other Care Providers Involved** (previous/current) - *(is the young person linked in with any other services? For example, CAMHS)* | | | | |
|  | | | | |
|  | | | | |

**Referrer Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** |  | **Relationship to the client** | |  |
| **Address** |  | | | |
| **Organisation** |  | | **Contact Number** |  |
| **I would like to be involved ongoing as a service provider** | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Client’s GP (if not the referrer):** | | | |
| **Name** |  | **Practice** |  |
| **Address** |  | | |

**Consent Details**

Please indicate who is consenting to collection, use and disclosure of personal health information:

|  |  |  |  |
| --- | --- | --- | --- |
| Adult client | Adolescent client (aged 16 or over) | Parent/guardian | Mature minor |

All information will be treated confidentially and will not be used for any other purposes that what is stated in the full consent form (signed during the first appointment). I am aware that this referral is being made. I understand I can withdraw from this service at any time. The client has been made aware of this referral.

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| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| Client name |  | Client signature |  |  | Date |
|  |  |  |  |  |  |
| Parent/guardian name |  | Parent/guardian signature |  |  | Date |

**Email this referral to** [**referrals@headspacearmadale.com.au**](mailto:referrals@headspacearmadale.com.au) **or fax to 08 9393 0399**