Referral Form

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

Client Details

Date of Referral	**DOB / /**	**Age**
Name	**Gender**	
Address		
Email	**Mobile**	**Home Phone**
Medicare No. ***(nothing billed without prior consent):***	**Reference No.**	**Expiry Date:**
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? ☐ Aboriginal ☐ TSI ☐ Other ☐ Unknown

Who does the young person live with?

Education/employment status?

Is the client aware and consented to the referral and wanting treatment?

<u>Next of Kin (MUST be completed if client is under 16 unless mature minor process followed)</u>

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

<u>Presenting Issues</u> *(please include here any information which may be useful as background information to assist with the referral e.g. mental health, drug and alcohol, vocational/educational, physical health, including past/current risk assessments)*

☐ Mental health ☐ Physical health ☐ Sexual health ☐ Alcohol/drugs
☐ Situational ☐ Vocational/education ☐ Social support ☐ Family support
☐ Eating ☐ Home/environment ☐ Friendships ☐ Relationships/sexuality

Mental Health Diagnosis *(Please attach copy of current Mental Health Treatment Plan if available)*

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Duration of presenting problem

ABN 71 131 368 735
headspace National Youth Mental Health Foundation Ltd is funded by the Australian Government Department of Health under the Youth Mental Health Initiative Program

Recent Stressors *Are there any legal proceedings pending? (please note headspace is unable to provide opinion re: legal matters or supporting documents)*

Client History *(Relevant biological, psychological, physical and social history, including family history)*

Relevant medications:

Risk to self or others *(include self-harm/suicide attempts, violence, threats of violence)*

Other Care Providers Involved (Previous/Current) *(is the young person linked in with any other services? For example CAMHS)*

Admissions to hospital related to mental health? **If so, how many?**

Referrer Details

Name **Relationship to the client**

Address

Organisation **Contact Number**

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.

Client name **Client signature** **Date**

Parent/guardian name **Parent/guardian signature** **Date**

FAX THIS REFERRAL TO HEADSPACE ARMADALE ON **9393 0399** or email to **referrals@headspacearmadale.com.au**

Please note that headspace Armadale does not provide crisis or acute care mental health services. For mental health emergencies contact the Mental Health Emergency Response Line on 1300 555 788.

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