Service Provider Referral Form

Once complete please send this form to: Fax: (02) 9193 8089 or Email: headspaceintake@newhorizons.net.au

Please note that headspace is not a Crisis or Emergency Service. In the event of a Mental Health Crisis, please call the NSW Mental Health Line on 1800 011 511. In an emergency, call 000 or go to a

hospital emergency department.



Date of Referral:

munication about service/s provided to them?

Expiry Date:

Cultural Background:

Consent At headspace Ashfield, it is our standard practice to obtain a parent or guardian's consent for young people under 16 years of age.

Has the young person consented to the referral: (If no, the referral cannot be accepted) Yes No If the young person is under 16 years of age, are the parents/carers aware of this referral? (If no, the referral cannot be accepted) Yes No Young person's details Surname: Legal first name: Date of birth: Preferred first name: Age: Gender assigned at birth: Current gender identity: Where does the (if "other", please specify): young person live? Address: Postcode: Suburb: State: Can we leave Home Phone: Email: a message? Does the young person con-Does the young person consent to email com-Mobile:

sent to SMS communication?

Is the young person of Aboriginal and/or Torres Strait Islander origin?

Does the young person require an interpreter?

Is the young person an Australian resident?

Educational Status (highest level obtained)

Employment Status:

Country of birth:

Medicare card number:

Is the young person on any Centrelink payments? (If so please list:)

Referrer Details

Name:	Relationship to young person:		
Organisation Name/Address:			
Contact number:	Email:		
GP Details (if known)			
Name:	Provider Number:		

Practice Name/ Address:

Mental Health Treatment Plan created?

(if yes, date of plan):

(if yes, please list language/s):

School/Institution:

Ref. No:

(if no, please specify):

Occupation:

Next of Kin Details

Name:	Relationship to young person:		
Address:		Phone:	
Can we contact next of kin?	Yes	No, unless in emergency	If young person is not contactable

Presenting Problem

What is the main concern for this young person?

Please include comment on symptoms, current functioning, mental and physical health concerns, school attendance refusal, family issues, drug/alcohol and vocational issues.

Is the young person at risk of harming themselves or others?

Detail: (Aggressive behaviour, Suicide/self harm, Plan, Access to Means, History of Attempts, Lethality, NSSI)

Has the young person ever received prior mental health care or are they currently receiving treatment? (by whom/dates/medications/ please include any hospital admissions):

If there is a discharge summary or other relevant documentation, please attach more information and detail as necessary. We will review this referral at our intake meeting and will respond regarding the outcome of referral as soon as we can.

<u>Office Use Only</u> Intake Clinician: Assessment Date: Referral Method: MasterCare Team:

Young person entered into HAPI?