Service Provider Referral Form

Once complete please send this form to:

Fax: (02) 9193 8089 or

Email: headspaceintake@newhorizons.net.au

Young person's details

Date of Referral :

Surname:

First name:

Gender:

Date of birth:

Address:

Suburb:

Post code:

Home Phone: Can we leave a message? Yes No

Mobile: Can we leave a message? Yes No

Indigenous Identity: Aboriginal Torres Strait Islander Both Neither

Educational Status (highest level obtained):

School/Institution:

Occupation:

Employment Status:

If no longer at school/work, how long has this been the case?:

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

Consent

Has the young person consented to the referral: Yes No

Referrer Details

Name:

Relationship to young person:

Organisation:

Address:

Suburb:

Post code:

Email:

Contact number:

GP Details

Name:

Provider Number:

Address:

Mental Health Treatment Plan created?

Date of plan:

Next of Kin details

Next of Kin name:

Relationship:

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 reason for this referral? Please include comment on symptoms, current functioning, mental and physical health concerns, school attendance, family issues, drug/alcohol and vocational issues.

Are there any other contributing 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.

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.

Office Use Only.

Date of Referral:

Assessment Date:

Referral Method:

MasterCare Team:

Young Person entered into HAPI?