Service Provider Referral Form

Once complete please send this form to:

Email: headspaceintake@newhorizons.net.au or Fax: (02) 9193 8089

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:** ___________________

Consent

At headspace Ashfield, it is 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? ☐ Yes ☐ No (if no, the referral cannot be accepted)

If the young person is under 16 years of age, are their parents/carers aware of this referral? ☐ Yes ☐ No (as above)

Young Person's Details

Last Name: __________________________ Legal First Name: __________________________

Date of Birth: __________________ Age: ________ Preferred First Name: __________________________

Gender Assigned at Birth: ____________________ Current Gender Identity: __________________________

Address: ____

Suburb: __________________________ State: ____________________ Postcode: ____________

Contact Number: __________________________ Can we leave a message? ☐ Yes ☐ No

Is the young person of Aboriginal/Torres Strait Islander origin? ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ No

Cultural Background: ____

Educational Status (highest level obtained): ____________ Institution/School: __________________________

Employment Status: ______________________ Occupation: __________________________

Medicare Card Number: ______________________ Reference Number: __________ Expiry Date: ____________

Is the young person on any Centrelink payments? ☐ Yes ☐ No (if yes, please list): __________________________

Referrer's Details

Name: __________________________ Relationship to Young Person: ____________________

Organisation Name/Address: ____

Contact Number: __________________________ Email: __________________________

General Practitioner's Details (if known)

Name: __________________________ Provider Number: __________________________

Practice Name/Address: ____

Mental Health Treatment Plan created? ☐ Yes ☐ No (if yes, date of plan): __________________________

Next of Kin's Details

Name: __________________________ Relationship to Young Person: ____________________

Address: __________________________ Contact Number: __________________________

Can we contact young person's next of kin? ☐ Yes ☐ No, unless in emergency ☐ If young person is not contactable

Office Use Only

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, alcohol/drug and vocational issues.

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

Detail: (Aggressive behaviour, Self-harm/Suicide, 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):

Intake Clinician: ______________________________________

Assessment Date: ____________________________________

Referral Method: _____________________________________

MasterCare Team: ____________________________________

Young person entered into HAPI? _________________________