

**Service Provider**

**Referral form**

Please Fax this form to: **(02) 9193 8089** or Email to: [headspaceintake@newhorizons.net.au](mailto:headspaceintake@newhorizons.net.au)

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| Please note that we are not an emergency service or Crisis Service. If you require immediate assistance, please call the NSW Mental Health Triage and Assessment Line on **1800 011 511**. Alternatively, direct your young person to the Emergency Department of their nearest hospital.  **We will review the referral at our case review meeting and will respond to you as soon as we can. If there is a discharge summary or other documentation, please send with this form.** |

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| **Referrer’s details** | | | | | |
| Name: |  | | | | |
| Position: |  | | Date: |  | |
| Organisation/School: |  | | | | |
| Email: |  | | | | |
| Contact no: |  | | Fax: |  | |
| **Consent** | | | | |
| Has the young person consented to referral? **(If no, the referral cannot be accepted)**  Yes No | | If the young YP is under 16 years, are the parents/carers aware? **(If no, the referral cannot be accepted)**  Yes No | | |

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| **Young person’s details** | | | | | | | |
| Surname: |  | | | | | | |
| Given names: |  | | | | | | |
| Preferred name: |  | | | | | | |
| Date of birth: |  | | | | Age: | |  |
| Contact No. |  | | | SMS consent: | | | Yes No |
| Email: |  | | |  | | |  |
| Does the young person consent to email communication from headspace Ashfield? Yes No | | | | | | | |
| Gender: | Male Female Other | | | | | | |
| GP Practice Details: |  | GP Name: | | | |  | |
| Medicare card # |  | Reference # | | | |  | |
| **Home/Living Situation** | | | | | | | |
| Street Address: |  | Suburb: | | | |  | |
| State: |  | Post code: | | | |  | |
| Where is the YP living: | At home with family/guardian  Shared accommodation  Staying with friends  Living alone  Med-long term supported accommodation  Refuge/crisis accommodation  Other: | | | | | | |
| **Emergency contact** | | | | | | | |
| Full Name: |  | | | | | | |
| Relationship to YP: |  | | Consent to be contacted other than in an emergency? Yes No | | | | |
| Contact No. |  | | | | | | |

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| Are other workers involved with YP’s care? If so, please list and detail the nature of the relationship. (GP, Psychiatrist, FACS etc) |  | |

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| School/TAFE/Uni attending: | |  | | Current year or highest level achieved: | |  | |
| Employment status: | |  | |
| Is this YP of the following background? | Aboriginal Torres Strait Islander Both | | | | | | |
| Country of birth? |  | | Level of English proficiency: | | Very well Well Not well Not at all | | |
| Interpreter required?  Language |  | |  | | | | |
| What cultural background does YP identify with? | | | | | | | |
| Any special need requirements that we need to be aware of? *(eg vision impaired, hearing impaired, cognitive impairment)* | | | | | | |

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| **REFERRAL INFORMATION** |
| **1. What is the main reason for this referral?**  **2. Symptoms**  **3. Current Level of Functioning** *(e.g. Anxiety, Depression, Auditory Hallucinations, Visual Hallucinations)*  **4. Are there any other contributing issues?**  *(e.g. Family History of MH Issues, Substance Use, Legal, Family, School, Physical)*  **5. Is the YP at risk of harming themselves or others? Details:** (Aggressive behaviours, *SI, Plan, Access to Means, History of Attempts, Lethality, NSSI*):  **6. Has the YP ever received prior mental health care or currently receiving treatment?**  *(Reason for previous care, Name and Contact details of service, are there any diagnoses, treatments, medication or hospital admissions?)* |

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| **Office use only** |

Date of referral:

Assessment Date:

Referral Method:

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| Intake clinician: |  |
| Mastercare Teams to be registered: |  |
| YP entered into HAPI? | Yes No |