

**Service Provider**

**Referral form**

Please Fax this form to: **(02) 9193 8089** or Email to: 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 |