**Referral Form**

**To be completed by services wishing to refer a young person**

**to headspace Bairnsdale**

**Referral Criteria and Guidance**

**headspace** Bairnsdale is a free, youth-friendly and confidential service available to young people aged 12-25 years, in the Bairnsdale and surrounding area. The services available at **headspace** Bairnsdale include:

|  |  |
| --- | --- |
| * Counselling with a psychologist or social worker |  |
| * Child and adolescent psychiatrist appointments |  |
| * Alcohol and drug workers * Employment assistance * Centrelink appointments * Allied Health Clinic * Therapeutic and support groups | |

**headspace** Bairnsdale work with young people experiencing mild to moderate mental health issues such as stress, anxiety, depression or grief.

**headspace** Bairnsdale is not an acute mental health / crisis service. If you have any immediate concerns regarding the safety of a young person, please call:

Kids helpline: 1800 551 800

Emergency Services: 000

Lifeline: 13 11 14

Please return the completed referral form to:

|  |  |
| --- | --- |
| **headspace** Bairnsdale | Phone: 03 5141 6200 |
| PO Box 677 | Email: [referrals@headspacebairnsdale.org.au](mailto:referrals@headspacebairnsdale.org.au) |
| Bairnsdale, VIC, 3875 |  |

**Self-Referral**

Young people can refer themselves to **headspace** Bairnsdale. Young people are encouraged to contact **headspace** Bairnsdale directly by either phoning, emailing or walk-in to the centre.

**Family and Friend Referral**

Family, carers and friends can refer a young person to **headspace** Bairnsdale. Please contact **headspace** Bairnsdale directly by either phoning, emailing or walk-in to the centre.

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| --- | --- |
| Young Persons Details | |
| Has the young person consented to this referral?  Yes  No | |
| Name |  |
| Address |  |
| Date of Birth |  |
| Phone Number |  |
| Gender | Female  Male  Transgender  Other: |
| Cultural Identity | Aboriginal or Torres Strait Islander  CALD |

|  |  |
| --- | --- |
| Referring Service Details | |
| Date of Referral |  |
| Name |  |
| Address |  |
| Organisation |  |
| Position in Organisation |  |
| Phone Number |  |
| Email |  |

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| Reason for Referral:  *Please include any information which may be useful to assist with the referral (e.g. mental health, drug and alcohol, vocational / educational or physical health including past / current risk assessments).* |
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| --- | --- | --- | --- |
| Does the young person have an existing GP? | Yes | No | Unsure |
| If yes, please detail: |  |  |  |
| Does the young person have an existing  Mental Health Treatment Plan? | Yes | No | Unsure |
| Does the young person require an interpreter? | Yes | No | Unsure |

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| Risks to Worker Safety: *Please include any known risks and current management strategies.* |
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