**headspace Bathurst Referral Form**

Once completed please email to: hs.Bathurst@marathonhealth.com.au

**Does the young person (YP) know about this referral?** Yes    
Have they given consent for this information to be exchanged? Yes    
Phone number of YP to check consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If not, the referral cannot be accepted. Get in touch and we’ll talk you through some other options.*

**Is the YP between 12 and 25 years of age?** Yes

**If under 16 years, are the parents/carers aware?** Yes

**Do you believe this young person is at risk of harm to themselves or other people?**  Yes  No

**headspace** is an early intervention and prevention service. If the young person is at risk of harm to themselves or to someone else, they are not suitable for **headspace** services. Please either contact the Mental Health hotline on 1800 011 511 (24 hours) for appropriate services, take them to your nearest hospital or call 000.

|  |  |  |
| --- | --- | --- |
| *Name* |  | |
| *Date of Birth* |  | |
| *Gender* |  | |
| *Address* |  | |
| *Who with?* | At home with family  Living alone  Staying with friends  Homeless  Refuge  Supported accommodation | |
| *YP Phone Number* |  | |
| *Email (optional)* |  | |
| *Name of parent/guardian (optional)* |  | *Parent/guardian contact number:* |

**Is YP of Aboriginal or Torres Strait Islander background?** Yes  No   
**Who is the best person to contact about this referral?** YP  Parent/Guardian  Referrer

**Is YP at school, TAFE, University or working?** Yes  No

|  |  |
| --- | --- |
| *Where?* | *Year / Level?* |

|  |
| --- |
| 1. What has led to this referral to **headspace**? What are the current concerns? |
| 2. Is the YP at risk of harming themselves or others? Are there any identifiable risk factors? (e.g. thoughts of suicide, self-harm, risk-taking behaviours, harming others) |
| 3. Anything else happening that might be affecting the YP? (e.g. family issues, exam stress, issues with friends or relationships) |
| 4. Anything from the past that might be affecting the YP now? |
| 5. Any previous mental health support/treatment, counselling, medication or diagnoses? |
| 6. What does the YP feel would be useful about coming to headspace, what are their goals? How motivated are they to come? |
| 7. Any other information that may be relevant? (e.g. family history of mental health issues, court involvement, intellectual disability, physical disability) |

**Referrer details**

|  |  |
| --- | --- |
| *Name* | *Position / Organisation* |
| *Best contact number* | *Email* |
| *Fax* | *Address* |

**Does YP have a GP?**  Yes  No

|  |  |
| --- | --- |
| *GP Name* | *Medical Centre / Practice* |

**Is there a current Mental Health Treatment Plan?** Yes  No

**Does the YP have an NDIS plan?** Yes  No

**Any other workers/services involved?**

|  |  |
| --- | --- |
| *Name* | *Position / Organisation / Contact number* |