headspace Referral Form

Referrer to complete form and fax to headspace Berri ***(08) 8582 5050***
or email to ***headspace@riverlandgp.org.au***

headspace Berri

Referrer's Details:			
Date of Referral :		**Name:**	
Organisation:		**Phone Number:**	
Does the client consent to referral? **headspace** is a voluntary service and all young people must consent to and be willing to engage in services.		Yes	No
Client Details:			
Name:		**DOB:**	
Gender:			
Male	Female	Intersex	Not stated
Address:			
Home Phone:		**Mobile:**	
Next of Kin:		**Permission to contact:**	Yes / No
GP:		**Permission to contact:**	Yes / No
Have you received Mental Health services before?		Yes	No
If YES, please explain: (CAMHS, school counsellor, private etc)			
Do you identify as:			
Aboriginal	Torres Strait Islander	Both	None
Country of Birth:	Australia	Other (please state):	
Do you speak a language other than English at home?		No	Yes (please state):
Do you live alone:		No (with who):	Yes
Accommodation:	Stable	Unstable	No fixed addressed

Reason for referral:		
Counselling	Young Parenting Program	Vocational education
General Practitioner	Group Program	Other:

Risk Assessment (per client)							
Suicidal ideation		**Suicidal intent**		**Current plan**		**Risk to others**	

Risk Assessment (as per referrer if young person unavailable at time of referral)							
Suicidal ideation		**Suicidal intent**		**Current plan**		**Risk to others**	

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Comments: