headspace Referral Form

headspace Berri

Organisation Facilitators Details:				
Date of Registration :		**Name:**		
Organisation:		**Phone Number:**		
Does the Young Person 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:**	**AGE:**	
Gender:	Male	Female	Intersex	Not stated
Address:				
Home Phone:		**Mobile:**		

Is the Young Person under 16? **Please note:** If you have answered yes the following questions are mandatory.		Yes	No
Is the young person's parent/guardian aware of this referral?		Yes	No
Parent / Guardian / Next of Kin/ Emergency Contact	**Permission to contact:**	Yes	No
Phone:			
Reason for not giving permission to contact parent/guardian (only required if young person is under 16)			

GP:	**When did you last see a Dr?**		
Would you like headspace to help you access a Dr's appt?		Yes	No
Have you received Mental Health services before?		Yes	No
If YES, please explain: (CAMHS, school counsellor, private etc.)			
Are you currently engaging with or being supported by any other services?		Yes	No
If YES, please explain:			

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

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Risk Assessment (per young person)							
Suicidal ideation		**Suicidal intent**		**Current plan**		**Risk to others**	
Risk Assessment (as per referrer)							
Suicidal ideation		**Suicidal intent**		**Current plan**		**Risk to others**	

Comments: