# Referral Form

## To be completed by services wishing to refer a young person to headspace Box Hill.

### Referral Criteria and Guidance

headspace Box Hill is a free, youth-friendly and confidential service available to young people aged 12-25 years in Whitehorse, Manningham and surrounding areas. The services available at headspace Box Hill include:

* Counselling
* Physical and Sexual health support
* Alcohol and drug workers
* Employment assistance
* Peer Support

headspace Box Hill works with young people experiencing mild to moderate mental health issues such as stress, anxiety, depression or grief.

headspace Box Hill 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 Box Hill | Phone: (03) 9810 9310 |
| Fax: (03) 9999 0626 | Email: boxhill.headspace@mindaustralia.org.au |

*Upon receiving of this referral, the young person will receive a* ***confirmation text message*** *from headspace Box Hill as an acknowledgement.*

If you wish to gain an update on the current waiting time, please contact us via 03 9810 9310

### Self-Referral

Young people can refer themselves to headspace Box Hill. Young people are encouraged to contact headspace Box Hill 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 Box Hill. Please contact headspace Box Hill directly by either phoning, emailing or walking in to the centre.

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| Young Person’s Details |
| Has the young person consented to this referral? [ ]  Yes [ ]  No |
| Name |  |
| Address |  |
| ­Date of Birth |  |
| Phone Number |  |
| Email (if known) |  |
| Gender | [ ]  Female [ ]  Male [ ]  Transgender [ ] Other: |
| Pronouns |  |
| Cultural Identity | [ ]  Aboriginal or Torres Strait Islander [ ] CALD |

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| Young Person’s Emergency Contact Details (if known) |
| Name |  |
| Relationship to Young Person |  |
| Phone Number |  |
| Email |  |

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

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| Details of Support People |
| The young person has consented to the following people being contacted by headspace to support appointments: [ ]  Yes [ ]  No |
|
| Name  |  | **Relationship to Young Person** |  |
| Phone Number |  | **Email** |  |
| Name  |  | **Relationship to Young Person**  |  |
| Phone Number |  | **Email** |  |
| Name  |  | **Relationship to Young Person** |  |
| 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). |
| Does the young person:* have an existing GP?
 | [ ]  Yes  | [ ]  No | [ ]  Unsure |
|  If yes, please detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| * have an existing Mental Health Treatment Plan?
 | [ ]  Yes  | [ ]  No | [ ]  Unsure |
| * 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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