Service Provider Referral Form

Once complete please send this form to:
Fax: (02) 9938 3099 or
Email: headspacebrookvale@newhorizons.org.au

headspace Brookvale

Please note that headspace is not a Crisis or Emergency Service. In the event of a Mental Health Crisis, please call the NSW Mental Health Line on 1800 011 511.

In an emergency, call 000 or go to a hospital emergency department.

Date of Referral:

Consent

At headspace Brookvale, it is our standard practice to obtain a parent or guardian's consent for young people under 16 years of age.

Has the young person consented to the referral: ☐ Yes ☐ No (If no, the referral cannot be accepted)

If the young person is under 16 years of age, are the parents/carers aware of this referral?

☐ Yes ☐ No (If no, the referral cannot be accepted)

Young person's details

Surname: Legal first name:

Age: Date of birth: Preferred first name:

Gender assigned at birth: Current gender identity:

Where does the young person live? (if "other", please specify):

Address:

Suburb: State: Postcode:

Home Phone: Can we leave a message? Email:

Mobile: Does the young person consent to SMS communication? Does the young person consent to email communication about service/s provided to them?

Country of birth: Cultural Background:

Is the young person of Aboriginal and/or Torres Strait Islander origin?

Does the young person require an interpreter? (if yes, please list language/s):

Is the young person an Australian resident? (if no, please specify):

Educational Status (highest level obtained) School/Institution:

Employment Status: Occupation:

Medicare card number: Ref. No: Expiry Date:

Is the young person on any Centrelink payments? (If so please list:)

Referrer Details

Name: Relationship to young person:

Organisation Name/Address:

Contact number: Email:

GP Details (if known)

Name: Provider Number:

Practice Name/ Address:

Mental Health Treatment Plan created? (if yes, date of plan):

Next of Kin Details

Name: Relationship to young person:

Address: Phone:

Can we contact next of kin? ☐ Yes ☐ No, unless in emergency ☐ If young person is not contactable

Presenting Problem

What is the main concern for this young person?

Please include comment on symptoms, current functioning, mental and physical health concerns, school attendance refusal, family issues, drug/alcohol and vocational issues.

Is the young person at risk of harming themselves or others?

Detail: (Aggressive behaviour, Suicide/self harm, Plan, Access to Means, History of Attempts, Lethality, NSSI)

Has the young person ever received prior mental health care or are they currently receiving treatment?

(by whom/dates/medications/ please include any hospital admissions):

If there is a discharge summary or other relevant documentation, please attach more information and detail as necessary.

We will review this referral at our intake meeting and will respond regarding the outcome of referral as soon as we can.

Office Use Only

Intake Clinician:

Assessment Date:

Referral Method:

MasterCare Team:

Young person entered into HAPI?