headspace Campbelltown Referral Form

Once complete please fax referral form to headspace Campbelltown on (02) 8823 1833. Alternatively you can send the referral by email to headspace.campbelltown@onedoor.org.au. Please allow 3-5 business days for your referral to be processed.

Important information regarding your referral, please read:
headspace is a service for young people between the ages of 12 to 25. We can only engage with young people who have provided consent to the referral. N.B. If YP is unable to provide informed consent due to mental state (e.g. psychosis), please contact us. •**Please note that we are not and emergency service**. If the young person is at high or acute risk of suicide, please contact emergency services on 000 or attend your nearest hospital emergency department. •Receipt of the referral form does not indicate acceptance to the headspace services. Suitability of the referral will be determined following assessment with the young person. •To complete the referral, you must attach relevant assessment notes, discharge summaries and/or additional information. • If you have any queries pertaining to your referral, please phone the relevant site using the contact details above.

Consent for referral: *If YP is unable to provide informed consent due to mental state (e.g. psychosis), please contact us.*		
Has the young person consented to and provided permission to exchange information in relation to this referral?	Yes	No

☐	Assessment for short-term mental health intervention with headspace. Does the YP have a Mental Health Care Plan? Yes No
☐	Drug and Alcohol Support
☐	Vocational Support
☐	Physical Health Support

Referrer details: *headspace will be corresponding with you using the below details. Please ensure that all details listed below are correct and legible.*
Name of Referrer:
Organisation:

Relationship to Young Person:
Designation:
Contact Number:
Fax:
Service Address: Email:
Parent/guardian/Next of Kin: * *please note that if the Young person is aged 15 and under, we will require a parent or guardian to be documented on this form*.
Name:
Relationship to young person:
Contact Number:
Do we have permission to speak with the person identified? ☐ Yes ☐ No
Emergency Contact:
Name:
Relationship to young person:
Contact Number:
Do we have permission to speak with the person identified? ☐ Yes ☐ No
Young Person's details:
Name:
Date of Birth:
Age:
Gender:
Address:
Suburb:
Post code:
Contact Number 1:
Contact Number 2:
Medicare No: Ref No: Expiry Date:

Interpreter Required?	☐Yes, Language:
Assistance with Reading/Writing?	☐Yes ☐ No

Presenting Issues:
Current presenting issues: *(please include duration, age of onset, and relevant pre-existing diagnoses)*
Impact of problem on functioning: *(e.g. relationships/school/home/work)*
Please indicate if there is any know family history of mental health conditions:
Previous/current engagement with other services:
Therapy goals: (friendly reminder that headspace Campbelltown is a short-term mild to moderate intensity service)

Risk Factors: ** IF risk is noted, please attach current safety plan **
☐ Suicide ☐ Non-accidental self-injury ☐ Harm to others ☐ Extreme social withdrawal ☐ Homelessness ☐Substance use ☐ Accidental death ☐ Non-compliance
Details:
Preference for clinician ☐ Female ☐ Male Preference for location ☐ headspace Campbelltown ☐Oran Park library (only Tue and Thursday) Referrer's Signature: Date: **By signing and dating this document, the referrer agrees that the above information is true and accurate.*