General Referral Form for Agencies/ Professionals

CONFIDENTIAL

Young Person (Client) Details Date:

Name Age DOB: Sex:

Address:

Ph: Mob Ph:

Lives with: Next of Kin / Other contact person:

NOK Relationship: NOK Ph: NOK Mob:

Educational Status (highest level obtained): School/Institution:

Usual Occupation: Employment Status:

If no longer at school/work, how long has this been the case?

Is the person on any Centrelink payments (if so please list):

Country of Birth Cultural/ Indigenous Identity:

Pref. Language: Language spoken at home:

Referrer Details

Name Job Title:

Organisation/Service:

Ph: Fax:

Is the client aware of the referral and wanting treatment?

Does the client have their own GP?

GP details (name, practice, address)

If yes, has a Mental Health Treatment Plan been created?

Presenting Problem (what are your main concerns regarding this young person? Incl mental and physical health concerns, drug/alcohol use and vocational issues):

What does the young person see as the problem?

Duration of current problem

Relevant background information:

Previous Mental Health Diagnoses/Treatment (by whom/ dates/ medications / include any developmental disabilities):

Other Services Involved (Previous/Current)

Risk (please tick if a current concern, and provide additional detail)

Suicide /Self Harm	Harm to Others	Homelessness
Substance Use/ Abuse	Extreme Social Withdrawal	School Avoidance/ Absenteeism
Psychosis/Mania	Other	

Details:

What assistance would you like from headspace?

Please attach more detail to this assessment if necessary.
Fax the completed referral form to headspace Campbelltown on 02 4627 0889 marked 'Intake' or send to PO Box 1138 Campbelltown NSW 2560 (please call 02 4627 9089 to ensure we have received it)
Please note that headspace does not provide crisis or acute care mental health services.
For mental health emergencies contact COMHET on 1300 787 799