(External) Group Registration Form

Date (DD/MM/YYYY): _____

Who is completing this form? ☐ Young person ☐ Other, please specify – Name: _____

Relationship to young person: _____

Contact number: _____

Email: _____

If you are completing this form on behalf of the Young Person, do you have their consent? ☐ Yes ☐ No

Does the Young Person have any risk or safety concerns? ☐ Yes ☐ No
If yes, please describe: _____

Title: ☐ Miss ☐ Ms ☐ Mrs ☐ Mx ☐ Master ☐ Mr Pronouns: _____

Given name (s): _____ Family name: _____

Preferred name: _____ Date of birth: _____ Age: _____

What gender do you identify as? ☐ Female ☐ Male ☐Non-binary ☐ Other: _____

Address: _____

Suburb: _____ State and postcode: _____

Mobile: _____ Parent/ carer's ph (if applicable): _____

Preferred contact: ☐ Mob no. ☐ Parent/Caregiver ph.

Email:

Can we send SMS to your mobile? ☐ Yes ☐ No

We send SMS (mobile appt reminders, and other text message) for recalls and reminders.

If you provide us with your mobile number or email address, you may get electronic messages from us. Please note, unencrypted forms of communication can be intercepted and are not considered secure for exchanging highly confidential or sensitive information

Are you of Aboriginal descent, Torres Strait Islander descent, or both?

☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

What cultural background do you identify with? _____

In which country were you born? ☐ Australia ☐ Other, *please specify:* _____

Do you speak a language other than English at home? ☐ No ☐ Yes: _____

Preferred language: _____ Do you require an interpreter? ☐ Yes ☐ No

Occupation: _____ List any known allergies: _____

If a student, what school do you go to?
(Tafe, USYD, UTS, Newtown HS etc.) _____

Do you have any disabilities/ health conditions? ☐ No ☐ Yes ☐Unsure

Do you require mobility assistance? ☐ No ☐ Yes

What is the young person's motivation or goals for wanting to join the groups?
(Being more social, learning new skills etc.) _____

OFFICE USE ONLY: ☐ Referral discussed with Clinical Lead/ CED officer: Staff Initial ____ ☐ ENTERED by Administration: Staff initial ____

Do you currently attend **headspace** Camperdown? ☐ No ☐ Yes

If Yes, please list your current clinicians / care coordinators at **headspace** Camperdown:

Have you attended a headspace centre in the past? ☐ No ☐ Yes, **headspace** Camperdown ☐ Yes, other **headspace** centre

Have you received any mental health treatment in the last 12 months? ☐ No ☐ Yes

If Yes, reason for treatment:

If Yes, where was treatment accessed?

If you were provided with any diagnoses, please list:

Are you currently attending any external services?

In the last 6 months have you ever felt really sad, down or depressed? ☐ No ☐ Yes

Have you ever deliberately harmed or injured yourself? ☐ No ☐ Yes

Have you ever had thoughts of suicide? ☐ No ☐ Yes

Have you had thoughts of intentionally harming or injuring another person? ☐ No ☐ Yes

On a scale of 1-10, how comfortable do you feel being amongst a group of people?
(10 being extremely comfortable,1 being not at all comfortable)

Are you sensitive to noise or other stimuli? ☐ No ☐ Yes

How did you hear about headspace Groups?

☐ Word of mouth ☐ Internet search ☐ Referral/ recommendation ☐ Other:

Name of referrer or service:

NB: We will only contact your emergency contact and next of kin if we can't get hold of you and are concerned about your safety

NEXT OF KIN ☐ Same as emergency contact ☐ Other, *please specify:*

Full name: Relationship to you:

Contact number:

EMERGENCY CONTACT (Australian contact)

Full name: Relationship to you:

Contact number:

Once completed, please email this form to headspace.camperdown@sydney.edu.au

Please note that acceptance into the headspace Camperdown group program will be at the discretion of the Clinical Lead and Group co-coordinator.

By submitting this form to headspace, you acknowledge that the young person is aware that we will be creating a file record for their group engagement.

OFFICE USE ONLY: ☐ Referral discussed with Clinical Lead/ CED officer: Staff Initial ____ ☐ ENTERED by Administration: Staff initial ____

headspace National Youth Mental Health Foundation is funded by the Australian Government Department of Health. *Client Information Form amended Mar 2023*

Privacy Notification And Consent Form

Before giving consent, it is important you have adequate information to inform your decision.

Please read the information below, along with our *Privacy and confidentiality* information leaflet and *Statement of client rights and responsibilities*. If you are having difficulties reading these documents, please speak to one of our staff and we will provide them in an alternative format.

Your personal information is protected by law, including the *Privacy Act 1988 (Cth) (Privacy Act).* As a client of headspace Camperdown, we need you to provide some of your personal details and medical history so that we can carry out our service to you. We require your consent to collect personal information about you and to use the information you provide in the following ways:

- Administrative purposes in running headspace Camperdown, billing including compliance with Medicare and Health Insurance Commission requirements, Group Participation
- Clinical purposes of running a case conference to establish and coordinate the management of the care needs of the patient. A fee is payable for this which we bulk bill to Medicare. A case conference is a process by which a multidisciplinary team carries out the following activities:
    - Discusses your history;
    - Identifies your multidisciplinary care needs;
    - Identifies outcomes to be achieved;
    - Identifies tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and
    - Assesses whether previously identified outcomes (if any) have been achieved.

- For disclosure to other workers within headspace Camperdown for us carry out our service to you
- For disclosure to others involved in your care outside of headspace Camperdown. This may occur through referrals and requests to other doctors and services, and in the reports or results returned to us following referrals
- For use to provide additional health services at headspace Camperdown
- For follow-up, reminders, and recall notices
- For research and quality assurance activities related to our provision of services
- To comply with any legislative or regulatory requirements for example the *Health Records and Information Privacy Act 2002 (HRIPA),* the *Public Health Act 2010,* and *Children and Young Persons (Care and Protection) Act 1998*. headspace Camperdown is a voluntary service and any care and treatment we provide to you is subject to your informed consent. For us to carry out our service to you, it may be reasonably necessary for some of your information to be communicated or transferred outside of headspace Camperdown. If you do not provide some of your information, it may influence our ability to provide appropriate services. You can request a copy of our privacy policy and privacy management plan for more information about the collection, use and disclosure of your information.

By signing this form:

- I have read the information above and understand the reasons why my information must be collected.

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- I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.
- I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.
- I understand that if my information is to be used for any other secondary purpose, my further consent will be obtained.
- I consent to the use and disclosure of my information by headspace Camperdown for the purposes set out above, subject to any limitations on access or disclosure of which I notify headspace Camperdown

OR (tick below)

☐ I am unsure and would like to discuss this further with someone from headspace Camperdown before signing.

Young person (client):

I, _____ _____ , (_____)
First name Surname Date of birth (dd/mm/yyyy)

give permission for headspace Camperdown to use and handle information collected about me and my health in accordance with the above conditions.

Signature: _____ Date: ____/____/_____

If person signing is not young person (i.e., Parent or legal guardian)

I _____ _____
First name Surname

give permission for headspace Camperdown to use and handle information collected regarding:

_____ , (_____)
Name of young person (client) Client's date of birth

Signature: _____ Date: ____/____/_____

Relationship to young person: _____

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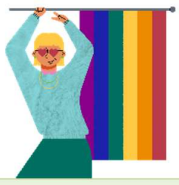
Headspace Camperdown group programs

Please tick the boxes for the group(s) that you are interested in:

		GROUP NAME	AGE GROUP	DAY AND TIME
☐		**ARTspace:** A social space to draw, paint, play boardgames or bring in a project you are working on and hang out with others.	**12-25 y.o**	Weekly Thurs 4:00pm – 5:30pm
☐		**Q-group**: A supporting space for LGBTQIA+ (or young people questioning their sexuality and gender) to meet and share ideas.	**12 – 25y.o**	Fortnightly Tues 4:00pm – 5:30pm
☐		**Autism ~~Community~~ Group:** A grou for autistic Young People to connect over fun activities, craft, games, and chats.	**16 – 25 y.o**	Fortnightly Tues 4:00pm – 5:30pm
☐		**International Students Group:** An opportunity for international students to meet, socially connect, and discuss common issues important to them.	**18 – 25 y.o**	Twice a month

Visit the headspace Camperdown website for an up-to-date calendar of current groups/programs.