# Referral to headspace Canberra

Unit 1/1 Torrens Street Braddon ACT 2612
Phone: 02 6113 5700

Return to headspace Canberra - **Fax: 02 6113 5744** or **Email: hcinfo@gph.org.au**

headspace Canberra is not a crisis service. If you have any immediate concerns for the safety of a young person, please call: Access Mental Health Team: **1800 629 354** Lifeline: **13 11 14** In an emergency, contact **000** immediately.

headspace Early Psychosis offers expert early intervention and specialist support for young people who are experiencing a first episode of psychosis or who are at risk of developing psychosis.

headspace Primary Care offers free and confidential support to young people aged 12-25 and their families and friends. We can help with mental health, general health, alcohol and other drug and work support.

Is this a direct referral to headspace Early Psychosis? Yes ☐ No ■ If yes, **Screener** must be attached.

**Details of Young Person** **Today's Date:**

| | | |
|---|---|---|
| First Name: | Last Name: | Preferred name: |
| Gender (optional): | Date of Birth: | |
| Address: | | |
| Contact number: | SMS consent? Yes ☐ No ☐ | Email: |
| Medicare #: | Reference #: | Exp date: |

**Consent**

| |
|---|
| headspace is a voluntary service; referrals will not be accepted without the consent of the young person. Has the young person agreed to this referral? Yes ☐ No ☐ |
| Does the young person have a Mental Health Treatment Plan? Yes ☐ No ☐ |
| If the young person is under 16 years, is a legal guardian aware of referral? Yes ☐ No ☐ 16 or over ☐ |
| Guardian's name: / Guardian's contact number: |

**Details of Referrer**

| | | |
|---|---|---|
| Name: | Service: | |
| Address: | | |
| Phone: | Fax: | Email: |
| Will you or another person from your service have continued involvement with the young person? Yes ☐ No ☐ Name: Phone: | | |
| Does the young person currently receive support from any other services? Yes ☐ No ☐ Name: Phone: | | |

Primary reason for referral: Mental Health ☐ Drug and Alcohol ☐ Vocational ☐ Other ☐ _____

Grand Pacific Health Uniting

What are some of the current issues? *(please include info about duration, age of onset and pre-existing diagnoses):*

What has been the impact of these? *(e.g. relationships, school, work, home etc.):*

What are the young person's goals and objectives?

Is the young person currently supported by other health services? *(If so, please provide service details below)* Yes ☐ No ☐

Does the young person consent to headspace Canberra exchanging information with these services to support this referral? *(If so, please provide contact details below)* Yes ☐ No ☐

**Signature of Referrer:** _____ **Signature of Young Person:** _____

Please note: If you are emailing this form to headspace Canberra, encrypt where possible. Please be aware that all forms of written communication involve an element of risk that information could be read by someone other than the intended recipient.