

referral form

ELIGIBILITY CRITERIA:

- **Referral from Service Providers will require a copy of ALL relevant collateral information** (including any assessments, discharge summaries & recovery documents) **prior to the referral being triaged**
- General Practitioners can fax and/or email a Mental Health Care Plan to headspace Capalaba instead of completing this referral form
- Referrals from **Probation and Parole** require social history, information on convictions and pending legal matters including dates, **prior to referral being triaged**. Please note we are a voluntary service.
- All referrals will be triaged by the Access and Engagement Team to assess eligibility and suitability for headspace Capalaba
- Outcome of referral will be provided directly to Service Provider via email, telephone and/or fax
- headspace Capalaba works **under the Medicare Billing Model (MBS)**, which means young people are **eligible for up to 10 Sessions** with Private Practitioners (Psychologists, Social Workers, Occupational Therapists) per calendar year
- headspace Capalaba also has access to **Psychological Therapies Program** Practitioners (Psychologists, Social Workers, Occupational Therapists) onsite where a young person can access up to 12 sessions if assessed to meet the criteria by the Access and Engagement Team
- For further information on services available at headspace Capalaba please access our website

1. REFERRER (INDIVIDUAL COMPLETING THIS DOCUMENT)

Contact Name: [Click here to enter text.](#)

Position / Role: [Click here to enter text.](#)

Organisation: [Click here to enter text.](#)

Postal Address: [Click here to enter text.](#)

Postcode: [Click here to enter text.](#)

Phone: [Click here to enter text.](#)

Mobile: [Click here to enter text.](#)

Fax: [Click here to enter text.](#)

Email: [Click here to enter text.](#)

Signed: _____

2. YOUNG PERSON BEING REFERRED (THESE DETAILS WILL BE USED TO CONTACT THE YOUNG PERSON/PARENT, FAMILY MEMBER, CARER)

First Name: [Click here to enter text.](#)

Surname: [Click here to enter text.](#)

Date of Birth: [Click here to enter text.](#)

Age: [Click here to enter text.](#)

Gender: [Click here to enter text.](#)

Address: [Click here to enter text.](#)

Suburb: [Click here to enter text.](#)

Postcode: [Click here to enter text.](#)

State: [Click here to enter text.](#)

Home Ph: [Click here to enter text.](#)

Mobile: [Click here to enter text.](#)

If Consent provided by young person, please provide details of their Parent/Family member/Carer:

Name: [Click here to enter text.](#)

Relationship to young person: [Click here to enter text.](#)

Mobile: [Click here to enter text.](#)

NOTE TO REFERRER

Please provide as much information as possible as it ensures the best quality of care, outcome and if required referral is afforded to the young person being referred.

If the young person is experiencing high levels of distress which may result in harm to themselves or others, please refer them directly to their local Emergency Department as headspace is not a Crisis Service or equipped to manage these types of emergencies.

3. REASON FOR REFERRAL

- Mental Health Physical Health Vocational/Social Alcohol/Other Drugs
- Other (please specify): [Click here to enter text.](#)

4. INFORMATION ABOUT THE YOUNG PERSON

(If Applicable) Risk to self or others (Include self-harm/suicide attempts, violence, threats of violence, vulnerability, child safety orders).

Date	Presenting issue	Previous Treatment	Current Treatment

(If Applicable) Other Agencies/Health Care Providers who are currently involved with the Young Persons Care: (e.g. Government, Non-Government, Psychiatrists, GP's and Community Services)

Name of Organisation	Contact Person	Address	Phone

5. PRESENTING ISSUES

- | | | |
|--|--|--|
| <input type="checkbox"/> ADHD / ADD | <input type="checkbox"/> EATING ISSUES | <input type="checkbox"/> PHYSICAL DISABILITY |
| <input type="checkbox"/> AGGRESSION | <input type="checkbox"/> EMOTIONAL ABUSE | <input type="checkbox"/> PRESENTATION TO E.D. |
| <input type="checkbox"/> ALCOHOL MISUSE | <input type="checkbox"/> EMPLOYMENT DIFFICULTIES | <input type="checkbox"/> PSYCHOSIS |
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> FAMILY DIFFICULTIES | <input type="checkbox"/> PTSD / TRAUMA HISTORY |
| <input type="checkbox"/> AUTISM SPECTRUM DISORDER | <input type="checkbox"/> FINANCIAL DIFFICULTIES | <input type="checkbox"/> RELATIONSHIP ISSUES |
| <input type="checkbox"/> BODY IMAGE CONCERNS | <input type="checkbox"/> INTELLECTUAL DISABILITY | <input type="checkbox"/> SCHOOL REFUSAL |
| <input type="checkbox"/> BULLYING | <input type="checkbox"/> OBSESSIVE COMPULSIVE BEHAVIOURS | <input type="checkbox"/> SELF-HARM |
| <input type="checkbox"/> CONTACT WITH CHILD SAFETY | <input type="checkbox"/> OTHER | <input type="checkbox"/> SEXUAL ABUSE |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> PENDING LEGAL MATTERS | <input type="checkbox"/> SOCIAL DIFFICULTIES |
| <input type="checkbox"/> DOMESTIC VIOLENCE | <input type="checkbox"/> PHYSICAL ABUSE | <input type="checkbox"/> STRESS |
| <input type="checkbox"/> DRUG MISUSE | | <input type="checkbox"/> SUICIDAL |

Please provide relevant information:

6. CONSENT OF YOUNG PERSON BEING REFERRED

I am aware that this referral is being made. I understand that I can withdraw from this referral or from the referred service at any time.

Please NOTE: Referrals will not be processed without signed consent.

I give permission for headspace Capalaba to use my contact details above for future contact with me. Yes No

I give permission for the **staff** of headspace Capalaba to obtain relevant information from referrer pertaining to this referral Yes No

I give permission for headspace Capalaba to contact the referrer and advise once an appointment has been arranged. Yes No

Signed: _____ Print Name: [Click here to enter text.](#) Date: [Click here to enter text.](#)

If under 18 years of age authorisation ideally should be provided by a parent/guardian.

Parent/Guardian Signed: _____ Print Name: [Click here to enter text.](#) Relationship: [Click here to enter text.](#)

7. THANK YOU FOR YOUR REFERRAL

Please return this form to headspace Capalaba

Ph: 1300 851 274

Fax: 07 3102 9218

Email: headspacecapalaba@wmq.org.au

Address: 1/27-39 Moreton Bay Road, Capalaba QLD

8. WHAT NEXT?

- On receipt of a referral headspace Capalaba will contact the service provider to advise of outcome and then if applicable will contact the young person for a phone triage and/or in addition to arrange a face to face appointment.
- All triage contact will be with a headspace Capalaba Access and Engagement Officer.