headspace Cowra Referral Form

Once completed please email to: hs.cowra@marathonhealth.com.au

Does the young person (YP) know about this referral? Yes ☐

Have they given consent for this information to be exchanged? Yes ☐

Is the YP between 12 and 25 years of age? Yes ☐

If under 16 years, are the parents/carers aware? Yes ☐

If not, the referral cannot be accepted. Get in touch and we'll talk you through some other options.

Is this young person at IMMEDIATE risk of harm to themselves or other people? ☐ Yes ☐ No

headspace is an early intervention and prevention service. If the young person is currently at risk of harm to themselves or to someone else, they are not suitable for **headspace** services. Please either contact the Mental Health hotline on 1800 011 511 (24 hours) for appropriate services, take them to your nearest hospital or call 000.

Name		
Date of Birth		
Cultural Identity	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Other …… Language spoke at home:…… Country of birth:……	
Gender/Preferred Pronouns		
Address		
Who with?	☐ At home with family ☐ Living alone ☐ Staying with friends ☐ Homeless ☐ Refuge ☐ Supported accommodation	
YP Phone Number		
Email (optional)		
Name of parent/legal guardian (optional if over 16 yrs)		*Parent/guardian contact number:*

Who is the best person to contact about this referral? YP ☐ Parent/Guardian ☐ Referrer ☐

Is YP at school, TAFE, University or working? Yes ☐ No ☐

1. What has led to this referral to **headspace**? What are the current concerns?
2. Is the YP at **non-immediate** risk of harm? Are there any identifiable risk factors? (e.g. thoughts of suicide, self-harm, harm towards others, risk-taking behaviours, substance use, risk of homelessness)

3. Anything else happening that might be affecting the YP? (e.g. family issues, exam stress, issues with friends or relationships)
4. Anything from the past that might be affecting the YP now?
5. Any previous mental health support/treatment, counselling, medication or diagnoses?
6. What does the YP feel would be useful about coming to headspace, what are their goals? How motivated are they to come?
7. Any other information that may be relevant? (e.g. family history of mental health issues, court involvement, intellectual disability, physical disability)

Does YP have a GP? Yes ☐ No ☐

GP Name	*Medical Centre / Practice*

Is there a current Mental Health Treatment Plan? Yes ☐ No ☐
Does the YP have an NDIS plan? Yes ☐ No ☐

Medicare Card: Name……..…..Number……..……Ref……Exp……..
Any other workers/services involved?

Name	*Position / Organisation / Contact number*

Referrer details

Name:	Position / Organization:
Email:	Best contact number:
Referrer signature:	Date:

Headspace use only
SRI noted in file title: Yes ☐ No ☐ N/A ☐
Escalated to Senior Clinical/Lead: Yes ☐ No ☐ N/A ☐