

Referral Form- Self-Referral Form



Once completed, please return to reception or email to:
hs.dubbo@marathonhealth.com.au

Date: ____ / ____ / ____

Self-Referral (young person)

Family & Friends Referral

Returning Client

*If GP or other service wants to make a referral, please complete the [Referral Form – External Services](#)

headspace is a voluntary early intervention and prevention service. If you (the young person) are at current risk of harm to yourself or to someone else, please either contact the Mental Health Line on 1800 011 511 (24 hours) for appropriate services or go to your nearest hospital or call 000.

If you are completing this form on behalf of a Young Person:

Is the Young Person aware you are contacting headspace Dubbo?

Yes No

Does the Young Person consent to the referral and headspace contacting them:

Yes No

*If no, the referral cannot be processed

If the young person is under 16 years of age:

Has a parent or legal guardian provided consent for the referral to take place:

Yes No

Parent/Guardian name: _____ Contact Number: _____

*If no, the referral may not be able to proceed – please contact us to discuss on (02) 6941 9023

Young Person's Details

Young Person's Name: _____ Gender: _____ Pronouns: ____ / ____

Date of Birth: ____ / ____ / ____ Age: _____ Medicare Number: _____ Exp: ____ / ____

Contact Number: _____ Is this number for Young Person? Yes No

*If no, who is it for: _____ Relationship to Young Person: _____

Can we send SMS messages to this number:

Yes No

Home Address: _____

Postal Address (if different from above): _____

Can we send mail to this address:

Yes No

Email address: _____ Is this Email address for Young Person? Yes No

*If no, who is it for: _____ Relationship to Young Person: _____

Can we send you emails (Such as our Welcome Pack):

Yes No

Demographics

Does the Young Person Identify as: Aboriginal Torres Strait Islander Both Non - Indigenous

Does the young person identify as culturally and/or linguistically diverse? Yes No

*If yes, what language: _____

Is an interpreter required? Yes No

Reason for Contact - (Goals and Challenges)

Does the Young Person have a current Mental Health Treatment Plan? Yes No Unsure

*If yes, please provide a copy to headspace

Safety

Have you (Young Person) had any thoughts of hurting yourself? Yes No Unsure

Have you (Young Person) had any thoughts of suicide? Yes No Unsure

Have you (Young Person) had any thoughts of harming others? Yes No Unsure

If yes, when was the last time you (Young Person) had these thoughts:

Are you (Young Person) experiencing Domestic or Family Violence? Yes No Unsure

Referrer's Details

Referrers Name: _____ Relationship to Young Person: _____

Referrers Contact Number: _____

Emergency Contact

Please provide the contact details for someone, over the age of 18, who you would feel comfortable with us contacting in the event of any concerns for your safety or wellbeing:

Name: _____ Contact Number: _____

Relationship to Young Person: _____

headspace use only

Form Collected by: _____ Role: _____

Signature: _____

Mastercare File created: Yes No N/A MCID: _____

Safety Risk Identified (SRI) noted in file title: Yes No N/A

Escalated to CTL if any safety questions marked as, 'Yes'? Yes No N/A CTL Signature: _____

Cultural and Demographic Information added to Mastercare? Yes No N/A

Welcome Pack provided: Yes No N/A

hAPI Profile created: Yes No N/A