headspace Outreach Project (hOP)
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 for young people aged 12-25. 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.

Nearest hOP Support Location: ☐ Bourke ☐ Brewarina ☐ Collarenebri ☐ Condobolin ☐ Coonamble ☐ Gulargambone ☐ Lightning Ridge ☐ Nyngan ☐ Walgett ☐ Warren

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

Clear Form

Send to headspace