

Headspace use only

Appointment Date: _____ Time: _____ Clinician: _____.

SRI noted in file title: Yes No N/A

Escalated to Senior Clinical/Lead: Yes No N/A

Referral Form- For Self Referral

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

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

Name (and Preferred Name)		
Date of Birth		
Pronouns		
Address		
Who with?	<input type="checkbox"/> At home with family <input type="checkbox"/> Living alone <input type="checkbox"/> Staying with friends <input type="checkbox"/> Homeless <input type="checkbox"/> Refuge <input type="checkbox"/> Supported accommodation	
Phone Number		
Email (optional)		
Name of parent/Carer		Parent/Carer number:
Name of emergency contact: (If Different from above)		Emergency contact number:

We use SMS messages to send reminders of appointment times and will send you a link to a survey before each appointment which we ask you to complete. We will also send a follow up SMS 3 months post closure with headspace Dubbo.

Please indicate the mobile number you would prefer us to use, ie this could be your own or your parent/carer mobile:

	Mobile Phone Number		Name			
Can we also contact you by?	Home Phone	Yes	No	Mobile	Yes	No
	Email	Yes	No			
Can we send mail to your home address?		Yes	No			

Medicare No:	
Ref No (number next to your name):	Exp Date:
Health Care Card (if applicable)	
Card Number:	Exp Date:

Are you of Aboriginal or Torres Strait Islander background? Yes No

Are you from a Culturally and Linguistically Diverse background? Yes No

Are you at school, TAFE, University or working? Yes No

<i>Where?</i>	<i>Year / Level?</i>
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1. What are your current concerns?
2. Has something happened lately that has impacted you?
3. Who are your current professional supports?
4. What would you/the young person like from headspace?
5. The following questions are about making sure you are safe: Do you currently have thoughts about, or are you deliberately injuring yourself Yes <input type="checkbox"/> No <input type="checkbox"/> Have you had previous thoughts of suicide? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes – when was the last time? Do you have current thoughts of suicide Yes <input type="checkbox"/> No <input type="checkbox"/>

Do you have thoughts of hurting someone else Yes No

Have you ever experienced issues of domestic violence? Yes No

6. Is there anything else you would like to add?

7. Preference of Phone appointment
or Face to face appointment in centre

Do you have a GP? Yes No

<i>GP Name</i>	<i>Medical Centre / Practice</i>
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Is there a current Mental Health Treatment Plan? Yes No

Do you have a NDIS plan? Yes No