headspace
Dubbo

# Referral Form- For External Services

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

**Does the young person (YP) consent to this referral?** 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.*

**Do you believe this young person is at risk of harm to themselves or other people?** ☐ Yes ☐ No

**headspace** is an early intervention and prevention service. If the young person is 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* | | |
| *Preferred name-if different to above* | | |
| *Date of Birth* | | |
| *Gender & Pro-nouns* | | |
| *Address* | | |
| *Who with?* | ☐ At home with family<br>☐ Staying with friends<br>☐ Refuge | ☐ Living alone<br>☐ Homeless<br>☐ Supported accommodation |
| *YP Phone Number* | | |
| *Email (optional)* | | |
| *Emergency Contact Name: (relationship)* | | *Emergency Contact Number:* |

**Is YP of Aboriginal or Torres Strait Islander background?** Yes ☐ No ☐

**Is YP from a Culturally and Linguistically Diverse background?** Yes ☐ ........................ No ☐

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

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

| *Where?* | *Year / Level?* |
|---|---|
| | |

**headspace** National Youth Mental Health Foundation is funded by the Australian Government Department of Health

| 1. What has led to this referral to **headspace**? What are the current concerns? |
| --- |
| 2. Are there any indications of self harm for the young person? Yes ☐ No ☐<br><br>Is the young person having any thoughts of suicide? Yes ☐ No ☐<br><br>Do you believe the young person is currently at risk of harm to themselves/other people? Yes ☐ No ☐ |
| 3. Has the young person ever experienced issues of domestic violence? Yes ☐ No ☐ |
| 4. Anything else happening that might be affecting the YP? (e.g. family issues, exam stress, issues with friends or relationships) |
| 5. Anything from the past that might be affecting the YP now? |
| 6. Any previous mental health support/treatment, counselling, medication or diagnoses? |
| 7. What does the YP feel would be useful about coming to headspace, what are their goals? How motivated are they to come? |

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|---|
| |
| 8. Any other information that may be relevant? (e.g. family history of mental health issues, court involvement, intellectual disability, physical disability) |
| 9. Preference of ☐ Phone appointment<br>or ☐ Face to face appointment in centre |

**Referrer details**

| *Name* | *Organisation* |
|---|---|
| *Position* | *Best contact number* |
| *Email* | *Address* |

**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 ☐

**Any other workers/services involved?**

| *Name* | *Position / Organisation / Contact number* |
|---|---|
| | |

*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 ☐