

headspace Eastern Shore and Early Psychosis referral form

- headspace Eastern Shore is suitable for young people aged 12-25 years with emerging mental health concerns and can provide short-term early intervention mental health treatment, work & study support, alcohol & other drug intervention, and physical or sexual health support.
- headspace Early Psychosis is suitable for young people aged 12-25 who are either at high risk of developing psychosis, or are experiencing symptoms of psychosis. headspace Early Psychosis cannot accept referrals for young people who have already received 12+ months of treatment for psychosis, for young people who live more than 1 hour away from our centre, or for young people that'd be better supported by another service or program.
- We encourage all service providers to call us on 6219 9870 to discuss suitability of a young person for our service prior to referring to either headspace Eastern Shore or headspace Early Psychosis.
- If a young person is at imminent risk of suicide, contact emergency services on 000.

Date of referral:		
Does the young person understand and consent to this referral?	yes <input type="checkbox"/>	no <input type="checkbox"/>
<i>(if young person is aged under 16)</i> are the young person's family or guardians consenting to this referral?	yes <input type="checkbox"/>	no <input type="checkbox"/>
Who is the best person to contact about this referral?	young person (16+)	<input type="checkbox"/>
	family	<input type="checkbox"/>
	referrer	<input type="checkbox"/>

Young person's details						
First name:					Surname	
D.O.B:		Gender		Phone		
Street Address						
Suburb		Post Code				
Can we leave messages on the provided number?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Can we send letters to the address?		No <input type="checkbox"/>
e-mail						
Cultural Identity	Not ATSI	Aboriginal (A) <input type="checkbox"/>	Torres Strait Islander (TSI) <input type="checkbox"/>	Both A&TSI	Culturally and Linguistically Diverse (CALD) <input type="checkbox"/>	
GP practice details						
Medicare Card Number		IRN		Expiry		

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Emergency Contact Details

For young people aged below 18 a **parent or guardian must be listed** (unless it is unsafe or inappropriate)
 For young adults (18–25), a **trusted adult** the young person identifies as supportive can be listed (e.g., parent, relative, family friend, partner, carer)

Name		Phone	
Email address		Relationship to young person	
Street Address			
Suburb		Post code	

Referrer Details

Name		Phone	
email			
Organisation			
Role			
Street Address			
Suburb		Post code	

Nature of support offered to young person from referring service

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Will your organisation continue to be involved with the young person?

Yes

No

If organisation not planning to be involved ongoing, please state why

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Reasons for referral

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short-term mental health support <input type="checkbox"/>	assessment with early psychosis service <input type="checkbox"/>	work & study support <input type="checkbox"/>
physical or sexual health support <input type="checkbox"/>	alcohol & other drug support <input type="checkbox"/>	

Please provide detailed information about your reasons for referral so we can make sure the young person is connected with the most appropriate support

(complete all fields for referrals to either headspace Eastern Shore or headspace Early Psychosis)

Presenting issues	
How long have these concerns been present?	
What impact are the presenting issues having on the young person's function?	

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Previous or current engagement with other services

(please detail purpose of and length of prior episodes of care as well as summary of care with referring service)

History of mental illness in young person's family

Has the young person received a formal diagnosis for a mental health condition?

(please provide documentation of diagnosis if available)

Young person's interests and strengths

What would the young person like to work on at headspace Eastern Shore?

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Risk factors:	
<input type="checkbox"/> suicidal ideation	<input type="checkbox"/> exposure to family violence
<input type="checkbox"/> suicidal attempt	<input type="checkbox"/> alcohol or other drug use
<input type="checkbox"/> non-accidental self-injury	<input type="checkbox"/> instability in home life or homelessness
<input type="checkbox"/> aggression or harm to others	<input type="checkbox"/> extreme social withdrawal or school avoidance
<input type="checkbox"/> aggression or harm from others	<input type="checkbox"/> misadventure
<input type="checkbox"/> forensic issues	<input type="checkbox"/> medical Issues
Details of risk factors: <i>(attach safety plan, discharge summaries, or relevant notes if available)</i>	

Referrer Signature

By signing this document, the referrer agrees that the information is accurate to their knowledge and that the young person and parent/guardian (if appropriate) is consenting to this referral and consenting to headspace Eastern Shore establishing a medical record and headspace hAPI profile (for outcome tracking) on their behalf.

Referrers name:

Signature:

Date:

Please email this completed referral to hello@headspaceEasternShore.com.au