

# headspace Eastern Shore referral form

- headspace Eastern Shore is a service for young people aged 12-25 years with mild-to-moderate mental health concerns.
- Suitability of all referrals will be determined following assessment with the young person (and their family if aged below 16).
- If a young person is at imminent risk of suicide, contact emergency services on 000.
- We encourage service providers to contact us on 6219 9870 to discuss suitability of a young person for our service prior to referring

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?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
e-mail							
Medicare Card Number			IRN			Expiry	
Cultural Identity	Not ATSI <input type="checkbox"/>	Aboriginal <input type="checkbox"/>	Torres Strait Islander <input type="checkbox"/>	Both A&TSI <input type="checkbox"/>			
GP practice details							

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Emergency Contact Details			
<b>Who Should Be Listed</b> <ul style="list-style-type: none"> <li>For young people aged below 18; a parent or guardian (unless it is unsafe or inappropriate).</li> <li>For young adults (18–25), a trusted adult the young person identifies as supportive (e.g., parent, relative, family friend, partner, carer).</li> </ul>			
Name		Phone	
Email address		Relationship to young person	
Postal Address			
Suburb		Post code	

Referrer Details			
Name		Phone	
		email	
Organisation			
Role			
Street Address			
Suburb		Post code	
Will your organisation continue to be involved with the young person?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If organisation not planning to be involved ongoing, please state why			

Reasons for referral		
mental health or wellbeing support <input type="checkbox"/>	sexual health support <input type="checkbox"/>	work and study support <input type="checkbox"/>
physical health support <input type="checkbox"/>	alcohol & other drug support <input type="checkbox"/>	group support <input type="checkbox"/>

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Please provide detailed information so we can understand the young person's needs and make sure they're connected with the most appropriate support

<b>Presenting issues</b>
<b>how long have these concerns been present?</b>
<b>what impact are the concerns having on daily functioning (school, work, relationships, mood, behaviour)?</b>
<b>what would the young person like to work on at headspace Eastern Shore?</b>
<b>young person's interests and strengths:</b>

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previous or current engagement with other services (including engagement with referring service):	
has the young person received a diagnosis for a mental health condition?	
risk factors:	
<input type="checkbox"/> suicidal ideation	<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"/> forensic Issues	<input type="checkbox"/> medical Issues
details of risk factors: <i>(attach safety plan if already completed)</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 hAPI profile on their behalf.

Referrers name:

Signature:

Date:

Please email this completed referral to [hello@headspaceEasternShore.com.au](mailto:hello@headspaceEasternShore.com.au)