

headspace Edmondson Park Referral Form



Email to: headspace_edpark@gph.org.au

Fax referral to: **TBC**

- We strongly recommend anyone referring a Young Person to also **call and speak to an Intake Worker** on **02 4604 3060**. Our intake workers are free to answer calls from 8:30am to 5:00pm, Monday to Thursday.
- Referrals are considered the week after we receive them. We'll be in touch after that to offer an appointment or to discuss who might be in a better position to support you / the Young Person.
- **We are not an emergency service.** If you / the Young Person needs immediate assistance, please call the mental health care line (**1800 011 511**) or go to the nearest hospital emergency department.

Although you may not be able to fill out all boxes provided, please keep in mind the more information provided on the referral form determines the Young Person's need to complete an intake assessment prior to allocation. If you could please complete this form with as much detail as possible to ensure a quicker, smoother transition for the Young Person and our team.

Date of referral:

Referrer details (if applicable)	
Name:	Relationship (Position and Organisation if appropriate):
Best contact number:	Email:

Consents	
Who is the best person to contact about this referral?	<input type="checkbox"/> YP <input type="checkbox"/> Parent / Guardian <input type="checkbox"/> Referrer
Does the YP know and consent to this referral and to taking part in an assessment?	Yes <input type="checkbox"/> No <input type="checkbox"/> (intake cannot proceed – please discuss this first with YP)
Does the YP/referrer give permission for headspace to seek information from previous services they have engaged with?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If under 14 years, do the parent/carers consent to treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
headspace collects some information by way of an online survey. Is the YP happy to complete this?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Contact Details	
Name:	
Age:	
Date of Birth:	
Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender (F-M) <input type="checkbox"/> Transgender (M-F) <input type="checkbox"/> Non-binary <input type="checkbox"/> Other
Pronouns used:	
Address:	
Who do they live with?	<input type="checkbox"/> At home with family <input type="checkbox"/> Living alone <input type="checkbox"/> Refuge <input type="checkbox"/> Staying with friends <input type="checkbox"/> Homeless <input type="checkbox"/> Supported accommodation
Phone Number (YP or carer):	
Email (YP or carer):	
Name and phone of parent/guardian in case of emergencies:	

Family and Friends Involvement	
<p><u>headspace values the involvement of family wherever possible.</u></p> <p>Does the young person have any family and friends they would like involved (name / relationship)?</p>	
Does the young person have any concerns about involving family?	

Work and Study	
Does the YP have a daytime activity?	<input type="checkbox"/> School <input type="checkbox"/> Work <input type="checkbox"/> University <input type="checkbox"/> Volunteering
Details (where / what year / what are they studying etc)?	
If the YP is not working / studying, would they be interested in accessing support from headspace work and study?	

Anything else happening that might be affecting the YP? (e.g. family issues, exam stress, issues with friends or relationships). Anything from the past that might be affecting the YP now?

Any previous mental health support / treatment, counselling, medication or diagnoses? What other supports are in place for the YP (organisations / services)?

Any other information that may be relevant? (e.g. family history of mental health issues, court involvement, intellectual disability, physical disability)

Does the young person have any physical health concerns? Is body image / self esteem a concern? Is drugs and alcohol a concern for the YP?

GP

Does the YP have a regular GP? Yes No

Is there a current Mental Health Care Plan? Yes No

GP Name:

Medical Centre / Practice:

Medicare card no / reference / expiry:
Centrelink Concession card CRN / expiry:

Suicide Screen. Please complete if the young person has indicated ANY suicidal thoughts / ideation above.

In the past month, have you:				No	Yes
a.	Thought that you would be better off dead			0	1
b.	Want to harm yourself			0	2
c.	Think about suicide			0	6
d.	Have a suicide plan			0	10
e.	Attempt suicide			0	10
f.	Have you ever in your lifetime make a suicide attempt:			0	4

Score	
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0	no current risk
1 - 5	low risk
6 - 9	moderate risk
10+	high risk

- Please consult immediately with the Clinical Lead for any young person who scores in the high risk category.
- Please complete a safety plan for any young person who scores in the moderate risk category and provide while you wait options including the link for the beyond blue safety plan. Please highlight the moderate score on the intake form. Consult with Clinical Lead if appropriate.
- Please confirm with any young person in the low risk category whether they can stay safe until we contact them and provide while you wait options.

For all young people, please remind them to call us if their circumstances change or they feel they cannot stay safe. Please provide while you wait options and information regarding the wait list groups.

For more information, please refer to the Clinical Handbook and Clinical Governance framework but always remember that if you are concerned, communicate this with the Clinical Lead or Manager.