headspace Emerald Referral Form

**headspace Emerald is an early intervention and prevention service. If the young person is experiencing high levels of distress which may result in harm to themselves or others, they are not suitable for headspace Emerald services. Please contact 1300 MH CALL on** **1300 642255 (24 hours) to speak with a registered nurse, take them to your nearest hospital, or call 000.**

|  |
| --- |
| **Important information regarding your referral, please read:** |
| * headspace Emerald is an **early intervention** and **prevention** service for young people between the ages of **12 to 25** who are struggling with **mild-moderate** mental health issues. We can offer **6-10 therapy sessions**, depending on a young person’s need.
* We can only engage with young people who have provided **consent** for the referral.
* Please note when a referral is received, it does not indicate acceptance to headspace Emerald’s services. Once the referral is considered, we will be in touch to either offer an intake appointment or discuss who might be a more appropriate care service to support the young person.
* From there, our team will be in touch within **3 business days** to let you know the outcome of the referral.
 |
| **Does the young person know about this referral?** | ☐ Yes ☐ No *If not, please gain consent, we can only engage with young people who have provided consent to the referral.* |
| **Is the young person between 12-25 years of age?** | ☐ Yes ☐ No*If no, the referral cannot be accepted. Get in touch and we’ll talk to you about some other options.* |

**REFERRER DETAILS**

|  |  |
| --- | --- |
| Referral Date |  |
| Organisation Name |  |
| Name  |  |
| Position  |  |
| Address |  |
| Preferred Contact *(Provide details for at least one contact)* | Telephone: |  |
| Email: |  |

**YOUNG PERSON IDENTIFICATION / CONTACT INFORMATION**

|  |  |
| --- | --- |
| Name |  |
| Date of Birth *(dd/mm/yyyy)**(Age for referral: 12yrs – 25yrs)* |  |
| Contact Number |  Safe to leave message? ☐ Yes ☐ No |
| Email Address |  |
| Current living situation | ☐ Accommodated     ☐ Homeless  |
| Home Address  |  |
| Mailing Address | Same as above:☐ Yes☐ No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | ☐ Aboriginal but not Torres Strait Island origin |
|  | ☐ Torres Strait Islander but not Aboriginal origin |
| Indigenous Status | ☐ Both Aboriginal and Torres Strait Islander origin |
|  | ☐ Neither Aboriginal nor Torres Strait Islander origin |
|  | ☐ Not stated/inadequately described |
| Gender | ☐ Male | ☐ Female | ☐ Other: |
| Preferred Pronouns | ☐ He/Him  | ☐ She/Her | ☐ They/Them  | ☐ Other: |

**DESIGNATED CONTACT PERSON (IN CASE OF AN EMERGENCY)**

|  |  |  |
| --- | --- | --- |
| Designated Person Contact Details | Name: |  |
| Relationship: |  |
| Telephone: |  |
| Consent to Contact | Consent for emergencies: ☐ Yes    ☐ NoConsent relating to service delivery: ☐ Yes    ☐ No (Appointment reminders etc)  |

**ELIGIBILITY**

|  |  |  |
| --- | --- | --- |
| Reason for Referral: | ☐ Mental Health | ☐ Physical & Sexual Health |
|  | ☐ Alcohol and Drugs | ☐ Work and Study |

**PRESENTING ISSUES**

|  |  |  |
| --- | --- | --- |
| ☐ Anxiety | ☐ Pain Management Issues | ☐ ADHD/ADD |
| ☐ Refusing School | ☐ Family Problems | ☐ Financial Difficulty |
| ☐ Depression | ☐ Physical Abuse | ☐ Loss of Appetite |
| ☐ Self-Harm | ☐ Relationship Issues | ☐ Physical disability |
| ☐ Harm or threats to others | ☐ Sexual Abuse | ☐ Intellectually Impaired |
| ☐ Stress | ☐ Domestic Violence | ☐ PTSD/Trauma History |
| ☐ Suicidal | ☐ Emotional Abuse | ☐ School Social Problems |
| ☐ Crying | ☐ Hallucinations and delusions | ☐ Asperger’s/Autism |
| ☐ Difficulty sleeping  | ☐ Eating Problems | ☐ History of hospitalisation |
| ☐ Drug Abuse | ☐ Body Image | ☐ Alcohol Abuse |
| ☐ Presentation to ED or Hospital | ☐ Bullying Others | ☐ Low Self Esteem |
| ☐ Past or present contact with CS | ☐ Pending Legal Matters | ☐ Functional decline |
| Main Issues: |  |
| Pre-existing diagnoses/Medication:  |  |

**FOR GP’S / HOSPITALS / OTHER ORGANISATIONS**

|  |  |
| --- | --- |
| Does the young person have a current risk assessment?  | ☐ Yes If so, please attach with referral☐ No |

**ADDITIONAL INFORMATION**

|  |  |
| --- | --- |
| Country of Birth |  |
| Main Language spoken at home |  |
| Dependents under 18 years  | ☐ Yes | ☐ No | ☐ Not stated |
| Employment/studying status: | ☐ Employed | ☐ Unemployed | ☐ Currently looking |
| ☐ Student | ☐ Unknown | ☐ Other: |
|  |
| Do they have a National Disability Insurance Scheme (NDIS) plan? | If yes Details: |
| Your preference for introduction of this participant? | ☐ Telephone | ☐ Online *(Videoconference)* | ☐ Face to Face |
| Preferred date, time, and contact number? |  |

**CONSENT: Where possible, have the young person sign this referral. If verbal consent has been obtained, please ensure the following information is provided to the young person and consent for the below is given**.

|  |  |
| --- | --- |
| I am aware that this referral is being made. I understand that I can withdraw from this referral or from the referred service at any time. | ☐ Yes ☐ No |
| I give permission for headspace Emerald to use my contact details above for future contact with me. | ☐ Yes ☐ No |
| I give permission for the staff of headspace Emerald to obtain relevant information from the referrer pertaining to this referral. | ☐ Yes ☐ No |
| I understand that headspace Emerald will provide the referrer listed on this referral, feedback of the outcome of the referral and intake assessment at headspace Emerald. This will only include intake attendance/non-attendance and outcome, not specific content discussed during an intake appointment.  | ☐ Yes ☐ No |
| **Young Person’s****Signature:** |  | **Date:** |  |
| **Referrer’s Signature:** |  | **Date:** |  |

Please email completed referral form to: intake.headspaceemerald@anglicarecq.org.au