

headspace Esperance Referral



Referrer Details – ignore this section if you are self-referring

Referrer's name		Permission to contact referrer? Yes <input type="checkbox"/> No <input type="checkbox"/>
Relationship to Young Person		Is Young Person aware of referral? Yes <input type="checkbox"/> No <input type="checkbox"/>
Referrer's phone/email		Date of referral

Young Person Details

Name		DOB	
Address			
Mobile +/- Home		If we leave a message, can we say we are from headspace? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Gender identity	Female <input type="checkbox"/> Male <input type="checkbox"/> non-Binary <input type="checkbox"/> self-describe:		
Pronouns	She/Her <input type="checkbox"/> He/Him <input type="checkbox"/> They/Them <input type="checkbox"/> self-describe:		

Cultural Identity

Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Aboriginal + Torres Strait Islander <input type="checkbox"/> Language group:	
non-Indigenous <input type="checkbox"/> self-describe:	
Country of birth	Ethnicity
Which language are you most comfortable speaking in?	
Interpreter required? Yes <input type="checkbox"/> No <input type="checkbox"/>	Interpreter specifics

Emergency Contact Details

Name			
Address			
Mobile		Home	
Relationship to Young Person		Can we contact this person about appointments? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Reason for referral

Mental Health <input type="checkbox"/> Drugs and/or Alcohol <input type="checkbox"/> Work and/or Study <input type="checkbox"/> Physical and/or Sexual Health <input type="checkbox"/>
--

Can you please tell us a little more about your reason for referral?

Additional Information

Is the Young Person currently in crisis or at immediate risk to self or others? Yes No

(headspace is not a crisis response service - please consider alternative referral if immediate support is required)

Risk assessment (please indicate)

Self-harm Suicidal thoughts Suicide attempt
 Violence/Aggression Psychosis/Mania Substance Use/Abuse
 Neglect/Abuse Homelessness Unsure none of the above

Is the Young Person subject to any current court orders or VRO's? Yes No

Can you please tell us a little more if you answered Yes or ticked any of the risk boxes above:

Involvement with other agencies/services

GP Name + Practice		Is it ok to contact them? Yes <input type="checkbox"/> No <input type="checkbox"/>
--------------------	--	--

Psychologist/Counsellor details		Is it ok to contact them? Yes <input type="checkbox"/> No <input type="checkbox"/>
---------------------------------	--	--

Is the young person currently receiving support from any other service? If yes, what service/s?	Is it ok to contact them? Yes <input type="checkbox"/> No <input type="checkbox"/>
--	--

Previous mental health treatment/diagnosis:

Relevant medical details, including medications (please attach existing Mental Health Treatment Plan, discharge summary, assessments, notes, other):

Client Consent

A part of the referral process to headspace is for us to learn about you and the other services involved in your life.

All information we find out about you, including from the hAPI (iPad) survey, will be treated confidentially, which means we will not share your information with anyone else unless you give us permission, or you are at serious risk. The information gathered will be securely stored in our Electronic Medical Record.

I have discussed headspace Esperance services with the referring agency (where applicable) Yes No

I have agreed to accept headspace Esperance services Yes No

I understand that any information collected by headspace is stored confidentially. I give my permission for headspace Esperance to obtain relevant information from the people listed above and from the hAPI (iPad) survey conducted at the beginning of every appointment Yes No

I consent to receiving emails and SMS from headspace Yes No

I consent to receiving letters from headspace Yes No

I am aware that this referral is being made and a headspace worker will be phoning me or my parent/guardian to discuss Yes No

I understand I can withdraw from headspace Esperance anytime Yes No

Young Person's name		Date	
---------------------	--	------	--

Young Person's signature	
--------------------------	--

Consent Method Verbal Written Digital Body Movement (non-verbal) Interpreter

If the young person is **under 16 years of age**, authorisation should, **where possible**, be provided by a parent/guardian/carer.

Guardian name		Guardian DOB		Date	
---------------	--	--------------	--	------	--

Guardian signature	
--------------------	--

Please note that Hope Community Services is unable to produce written reports or expert evidence for use in court proceedings (whether for family law matters, or otherwise). If this is what you require, it is recommended you seek assistance from a qualified professional specialising in such reports.

queries or to chat with headspace regarding this referral: (08) 9034 5160

what happens next?

- This completed referral form needs to be received by headspace Esperance via one of the following methods:

email
headspace.e@hopecs.org.au
email subject line: Referral - *first name last name*
in-person
83b Dempster Street – between the hours of 8:30am-5pm Mon - Wed, 9:30 - 7pm Thurs + 8:30am - 3:30pm Fri

- If we require further information from you, we will make contact ASAP for the information, then your referral will move to step 3 (below).
- If we do not require further information from you, please know that this referral will be triaged + assessed by our Clinical Team within 2 working days. We will contact the Young Person regarding the outcome of the referral and collaborate with any other person or service the Young Person has consented too moving forward. Generally, an initial appointment will be offered for the Young Person to meet with a headspace worker and engage in further assessment. If the referral is assessed to be outside our service scope, we will contact the Young Person + Referrer to suggest alternative support options.