headspace Esperance Referral

Referrer Details – ignore this section if you are self-referring			
Referrer's name		Permission to contact referrer? Yes ☐ No ☐	
Relationship to Young Person		Is Young Person aware of referral? Yes ☐ No ☐	
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 ☐ No ☐	
Gender identity	Female ☐ Male ☐ non-Binary ☐ self-describe:		
Pronouns	She/Her ☐ He/Him ☐ They/Them ☐ self-describe:		

Cultural Identity			
Aboriginal ☐ Torres Strait Islander ☐ Aboriginal + Torres Strait Islander ☐ Language group:			
non-Indigenous ☐ self-describe:			
Country of birth		Ethnicity	
Which language are you most comfortable speaking in?			
Interpreter required? Yes ☐ No ☐		Interpreter specifics	

Emergency Contact Details			
Name			
Address			
Mobile		Home	
Relationship to Young Person		Can we contact this person about appointments? Yes ☐ No ☐	

Reason for referral
Mental Health ☐ Drugs and/or Alcohol ☐ Work and/or Study ☐ Physical and/or Sexual Health ☐
Can you please tell us a little more about your reason for referral?

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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 ☐ No ☐
Psychologist/Counsellor details		Is it ok to contact them? Yes ☐ No ☐
Is the young person currently receiving support from any other service? If yes, what service/s?		Is it ok to contact them? Yes ☐ No ☐
Previous mental health treatment/diagnosis:		
Relevant medical details, including medications (please attach existing Mental Health Treatment Plan, discharge summary, assessments, notes, other):		

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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?

1. 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

2. If we require further information from you, we will make contact ASAP for the information, then your referral will move to step 3 (below).

3. 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.