**Referral Guidelines**

**About headspace Geraldton**

**headspace** Geraldton is a free, youth-friendly and confidential service for young people aged 12 – 25 years.

Lead by Youth Focus, **headspace** Geraldton, brings together a range of services, to provide a holistic “one-stop-shop” for young people. We offer information, intake, assessment and referral. At **headspace** Geraldton we offer the following supports and services including:

|  |  |
| --- | --- |
| * Youth Friendly Physical Health Practitioner | * Tele-psychiatry Service |
| * Youth Counselling | * Alcohol & Drug Education Counsellors |
| * MBS & ATAPS Psychological Services  *(Under GP Mental Health Treatment Plans)* * Youth Career Guidance Support | * Support Groups * Youth Reference Group |
|  |  |

**PLEASE NOTE:**

**headspace Geraldton is not an acute mental health/crisis service. If you have any immediate concerns regarding the safety/wellbeing of a young person, please call Geraldton Regional Hospital Emergency Department on (08) 9956 2222; Mental Health Emergency Response Line (MHERL) on 1800 555 788; Lifeline on 13 11 14; or Kids Helpline on 1800 55 1800. In an emergency, contact 000 immediately.**

**HOW TO REFER:**

**Self-Referral**

Young people are encouraged to make contact with the **headspace** Geraldton service directly.

**By phone/email**

Call (08) 9943 8111 within office hours or email intake@headspacegeraldton.com.au, a worker will contact the young person within a week to make an appointment.

**Drop in**

Young people can call into **headspace** Geraldton, 193 Marine Terrace, Geraldton, between 10am and 4pm, Monday – Friday. Staff will endeavour to see the young person the same day or the next available appointment will be offered.

**Professional Referral**

GP’s, Allied Health Professionals, community-based agencies and educational institutions can all refer young people to **headspace** Geraldton using the Referral Form attached. General Practitioners should include a mental health care plan (if appropriate) for the young person and attach this to the **headspace** Geraldtonreferral form.

**Family Referral**

Families, carers or friends can refer a young person to **headspace** Geraldton in person or by phone/email (see details above). The young person needs to be aware of and consent to the referral and be willing to meet with a member from the **headspace** Geraldton team. Once receipt of referral has been confirmed, a worker will contact the young person within a week to make an appointment. Families, parents or carers who have a young person engaged with **headspace** Geraldton can also access our centre to discuss service provision.

For more information regarding **headspace** Geraldton, please contact us directly or visit our website at [www.headspace.org.au/geraldton](http://www.headspace.org.au/geraldton).

**REFERRAL FORM – Please complete all pages**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Referral:** |  | | | | | **Referral Source:** | | | | | Self Doctor:  School Friend/Family Member  Service Provider: | |
| **Is client aware of and consent to the referral?**  Yes  No | | | | | | | | | | | | |
| **Client Details** | | | | | | | | | | | | |
| **Name:** |  | | | | | **DOB:** |  | | | | | |
| **Address:** |  | | **Gender** | | | Male  Gender Diverse  Intersex  Female  Indeterminate  Other: | | | | | | |
| **Phone:** |  | | **Email:** | | |  | | | | | | |
| **Cultural/**  **Indigenous Identity:** |  | | **Preferred language:** | | |  | | | | | | |
| **Educational Status:** |  | | **School/**  **Tertiary Institution:** | | |  | | | | | | |
| **Employment Status:** |  | | **Usual Occupation** | | |  | | | | | | |
| **If no longer at school/work, how long has this been the case?** | | | | | |  | | | | | | |
| **Emergency Contact Details** | | | | | | | | | | | | |
| **Name:** |  | | **Phone:** | | |  | | | | | | |
| **Address:** |  | | **Email:** | | |  | | | | | | |
| **Relationship:** |  | | **Can we contact this person about your engagement at headspace?** | | | | | | | | | Yes  No |
| **Referrer’s Details** | | | | | | | | | | | | |
| **Referrer’s Details:**  Same details as Emergency Contact | | | | | | | | | | | | |
| **Name:** |  | | | | **Relationship/ Job Title:** | | | |  | | | |
| **Address:** |  | | | | **Organisation:** | | | |  | | | |
| **Phone:** |  | | **Email:** | |  | | | | | | | |
| **Background Information and Presenting Issues** | | | | | | | | | | | | |
| **Reason/s for Referral:** | | Mental Health  Drugs and Alcohol  School/Work  Physical/Sexual Health | | | | | | | | | | |
| **What are your main concerns regarding this young person?** | |  | | | | | | | | | | |
| **What does the young person see as the problem?** | |  | | | | | | | | | | |
| **Previous mental health diagnosis or treatment?** | |  | | | | | | | | | | |
| **List other services involved, including GP if young person has one:** | |  | | | | | | | | | | |
| **Has a Mental Health treatment Plan (MHTP) been created?** | | Yes  No  Unsure | | **What is the duration of the current problem?** | | | | | |  | | |
| **Risk – please tick if current concern and provide more detail** | | Suicide/Self harm  Harm to others  Homelessness  Substance Use/Abuse  Psychosis | | | | | | Harm from others  Extreme social withdrawal  School avoidance  Other, please provide details: | | | | |
| **Other relevant background information:** | |  | | | | | | | | | | |
| **What assistance would you like from headspace Geraldton?** | |  | | | | | | | | | | |