Referral Form

Please send the completed referral form via email or fax:
Email: info@headspacegladstone.com.au | Fax: (07) 4803 9100
For any queries, please contact us on (07) 4903 1921

headspace Gladstone

Important information regarding your referral, please read:

- **If the young person is experiencing high levels of distress which may result in harm to themselves or others, or is at high or acute risk of suicide, they are not suitable for headspace services.** Please contact 1300 MH CALL on 1300 642 255 (24 hours) to speak to an Acute Care Clinician, refer them directly to the Emergency Department of the nearest hospital, or contact emergency services on 000.
- headspace Gladstone is an **early intervention and prevention service**. We offer **short-term brief intervention** to young people between the ages of 12 to 25 who are **experiencing mild to moderate** mental health issues. Young people lead the way; they choose when and how often to access the service.
- Please note we are a **voluntary** service, and we can only engage with young people who have **provided consent** to the referral.
- Please note that receipt of the referral does not indicate acceptance to the headspace Gladstone services. headspace Gladstone may support the young person by referring them to other services when deemed appropriate.
- Please provide and attach as much information as possible to help our team provide the best quality care for the young person.
- We will acknowledge that we have received this referral, via email within 1 business day.
- The referral will be actioned within 7 days.

Young Person's details:

Full Name:			
Preferred Name:			
Date of Birth:		**Age:**	
Gender:		**Preferred Pronouns:**	
Address:	**Suburb:**	**Postcode:**	
Contact Number:		**Safe to leave a message?**	☐ Yes ☐ No
Email (optional):			
Cultural Background:			
Interpreter Required?	☐ No ☐ Yes, Language:		
Assistance with Reading or Writing?	☐ Yes ☐ No		

Referrer details:

Who is referring?	☐ Self ☐ Service Provider ☐ Family/Friend ☐ GP ☐ School ☐ Other, please specify:		
Name of Referrer:			
Referral Date:			
Organisation/Clinic/School (if applicable):			
Position / Relationship to Young Person:			
Contact Number:		**Fax Number:**	

headspace National Youth Mental Health Foundation is funded by the Australian Government Department of Health

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Email Address:	
Do you wish to be part of our emailing list?	☐ Yes ☐ No

Parent/Carer/Next of Kin:

Name:			
Relationship:		**Contact Number:**	

Do we have consent from the young person to speak with the Parent/ Carer/ Next of Kin about this referral? ☐ Yes ☐ No

The below question is only required for young people under 16 years of age. headspace Gladstone suggests ensuring parent/carer(s) are aware of the referral (as appropriate) as we value their input and involvement in supporting young people.

Are the parent/guardian(s) aware of this referral? ☐ Yes ☐ No

Primary reason(s) for Referral:

☐ Short-term, brief Mental Health Intervention for mild/moderate mental health issues

Does the young person have a current GP Mental Health Treatment Plan? ☐ Yes ☐ No
If yes, please attach a copy to this referral

☐ Drug and/or Alcohol Counselling/Support	☐ Vocational Support
☐ Physical Health Support	☐ Other, please specify:

Presenting Issues and Relevant History: Please attach additional pages of information if necessary

What led to the referral to headspace? What are the current concerns? (please include duration, age of onset, and relevant pre-existing diagnoses):

☐ Bullying	☐ Relationships	☐ School	☐ Anxiety
☐ Depression	☐ Sexuality / Gender Identity	☐ Social Concerns	☐ Sleep
☐ Anger	☐ Conflict in Home Environment	☐ Work & Study	☐ Other: _____

Please indicate if there is any known family history of mental health conditions:

Any <u>previous</u> mental health support/treatment, counselling or medication? (please include contact information, and if current– relevant assessment information should be attached)

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Is the young person <u>currently</u> engaged with any supports, or have they also been referred elsewhere?
(please include details and contact information)

How does the young person feel about coming to headspace? How motivated are they to attend?

What do you hope headspace Gladstone can achieve for this young person?

Risk Factors:

☐ Suicide	☐ Deliberate self-harm	☐ Harm to others	☐ Domestic/Family Violence
☐ Homelessness	☐ Accidental death	☐ Social Isolation	☐ Child Safety involvement
☐ Substance use	☐ Non-compliance	☐ Social withdrawal	☐ Other: _____

Please provide details and attach current safety plan (if applicable):

Consent: Where possible, please have the young person sign this referral. If verbal consent is obtained, please ensure the following information is provided to the young person and consent for 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.
☐ I give permission for headspace Gladstone to use my contact details above for future contact with me
☐ I give permission for the staff of headspace Gladstone to obtain relevant information from the referrer relating to this referral
☐ I understand that headspace Gladstone will provide the referrer feedback of the outcome of the referral and initial session at headspace Gladstone. This will only include initial appointment attendance/non-attendance and outcome, not specific content discussed during the initial appointment.

Client Signature:		**Date:**	
Referrer's Signature:		**Date:**	

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