headspace Platform Gosford, Lake Haven and Wyong Referral form

For any inquiries, please call us at **Gosford 4304 7870, Lake Haven 4394 9100 (Mon-Fri) or Wyong 4394 9180 (Tues-Thurs)**
Please fax completed referrals to **headspace** Lake Haven on 4394 9111, Gosford 4304 7899 or email them to cclhd-headspace-info@health.nsw.gov.au

Important information about your referral

- headspace is a service for young people aged 12-25
- We can only provide support to young people who agree and consent to the referral being made headspace Gosford, Lake Haven and Wyong, **are NOT an acute mental health or crisis service**
- If you have any immediate concerns for yourself as a young person, or for the young person you are referring, please call the Mental Health line on **1800 011 511**
- Alternatively you, or the young person you are referring, can present to the Emergency Department at the nearest hospital, or call 000
- For crisis counselling telephone support please contact **Lifeline** on **13 11 14, Kids Helpline** on **1800 55 1800** or **13YARN** on **13 92 76**
- Completing this referral form does not mean the young person is accepted into the service
- headspace will aim to respond to your referral within 3 business days

Young Person's Details

Date: **Please type details onto form, if possible**

Preferred headspace site: ☐ Gosford ☐ Lake Haven ☐ Wyong

Name: _____ Date of Birth: _____

Address: _____

Is it okay for us to send **headspace** branded documents to this address? Yes ☐ No ☐

Phone: _____ email: _____

Gender: _____ Preferred pronoun/s: _____ Medicare No: _____ Exp: ____/____

Emergency Contact: _____
Name: *Phone number:*

Relationship to young person: _____

Does the young person identify as Aboriginal or Torres Strait Islander? Yes ☐ No ☐ If yes, traditional place name? _____

What Culture does the young person identify with? _____

Does the young person require an interpreter? Yes ☐ No ☐ If yes, which language? _____

Does the young person have an existing GP? Yes ☐ No ☐

Doctor's name: _____ Practice Name: _____

Referrer's Details

Name: _____ Phone: _____

email: _____

Relationship to young person: _____
Organisation (if applicable)

Consent

Does the young person consent to this referral? Yes No If Under 14, is parent consent provided? Yes No

Reason for Referral

What are some of the current issues? *(please include info about pre-existing diagnosis, duration of current issues etc)*

What has been the impact of these? *(eg relationships, school, work, home etc)*

What are the young person's goals and objectives in seeking support from headspace?

Is there a family history of mental ill health? *If yes, please provide details*

Is the young person currently supported by other health services? *(If so, please provide service details below)* Yes ☐ No ☐

Does the young person consent to **headspace** Gosford, Lake Haven and Wyong exchanging information with these services to support this referral? Yes ☐ No ☐

Risk Factors – Current & Previous

☐	Suicide	☐	Alcohol & Drug Use
☐	Self-Harm	☐	Homelessness
☐	Harm to Others	☐	Extreme Social Withdrawal
☐	Domestic Violence	☐	

Please provide further details: e.g. recent suicide thoughts, plans, symptoms, behaviours, concerns from others about risk, at risk mental state (depressed, despair, hopelessness, guilt, marked agitation, intoxication)

headspace Service Interest

☐	Welcome Support (information about headspace)	☐	CRP-Case Management Support
☐	Counselling Support (10 sessions – Mental Health Care Plan from GP is required)	☐	GP/Nurse Clinic
☐	Single Session (1 session + follow up phone call)	☐	Work and Study Support
☐	Brief Intervention (4 sessions)	☐	Not Sure
☐	Groups *(social, psych-educational)*	☐	