headspace Platform (hS Gosford, hS Lake Haven and hS Wyong) Referral Form

Date:

☐ I am a young person who is referring myself to **headspace (please fill in section A)**

☐ I am referring a young person to **headspace (please fill in sections A & B)**

☐ I am accompanying a young person and filling out this form on their behalf **(please fill in section A, section B optional)** ***Please note: All young people under 14 years of age must have signed parental/carer permission to access headspace***

(Section A) Details of Young Person

Name:	D.O.B
Address……..... Is this Address? Private ☐ Public Housing ☐ Refuge/other Shelter ☐ Does the young person live with? Both parents ☐ One Parent ☐ Friends ☐ Relatives ☐ Other ☐ pls specify …… Are we able to send mail to this address? Yes ☐ No ☐ Preferred headspace location: Gosford ☐ Lake Haven ☐ Wyong ☐	Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Contact Number…….. Can we leave voice message or send SMS to confirm appointments? Yes ☐ No ☐

In which Country was the young person born? Australia ☐ No ☐ specify……

☐ AVO in place (if yes, please provide copy of AVO with referral/prior to 1st appointment)
☐ Family Court Orders (if yes, please provide copy of Court Orders with referral/prior to 1st appointment)
☐ Parenting Agreement/Mediation Orders (if yes, please provide copy prior to 1st appointment)

Does the young person have a regular GP? Yes ☐ No ☐ Name and Practice…….....

Does the young person have a current mental health diagnosis? No ☐ Yes ☐ If yes pls provide details……

Secondary Diagnosis No ☐ Yes ☐ If yes pls provide details……

Does the young person have any physical health diagnoses/conditions? No ☐ Yes ☐ If yes pls provide details……

Is the young person currently taking medication? No ☐ Yes ☐ If yes pls provide details……...

Is the young person a full time student? Yes ☐ No ☐ If Yes, What year (eg 8,9,10,) is the young person in?.....

If no, What year did the young person complete last at school (eg 8,9,10,)……

Is the young person employed F/T P/T or casual? Yes ☐ No ☐

Is the young person interested in employment support programs? Yes ☐ No ☐

Does the young person receive a benefit from Centrelink Yes ☐ No ☐ Unemployment ☐ DSP ☐ Other ☐**……..**

Does the young person have a current NDIS package or NDIS application in progress? No ☐ Yes ☐ If yes pls provide details…… (Please note headspace is not an approved NDIS provider).

Does the young have person have a current Victims of Crime Counselling package approved? No ☐ Yes ☐ If yes pls provide details……

Has the young person been engaged in with a CCLHD Mental Health Service (CAMHS or ACT) or Alcohol and Drug service in the last 12 months? No ☐ Yes ☐ If yes pls provide details……

Has YP been engaged with private psychologist in the past 6 months? No ☐ Yes ☐ If yes pls provide name of psychologist and how many sessions used on MHCP……

Does the young person identify as: Aboriginal ☐ Torres Strait Islander ☐ No ☐

If so, would the young person prefer to speak to an Aboriginal or Torres Strait Islander Youth Worker from Youth Health, if one is available? Yes ☐ No ☐

Does the young person identify as being a part of Cultural Linguistically Diverse background? Yes ☐ No ☐
If yes please provide details……

Does the young person speak a language other than English at home? Yes ☐ No ☐ If Yes,

Language Spoken…… Would the young person like an interpreter? Yes ☐ No ☐

Medicare Card Number……Ref……..Expiry Date……..
Health Care Card Number (if Applicable)……...Expiry Date……

When a young person attends **headspace**, our reception staff will ask you to complete a quick survey on our Ipads.
Will the young person have any issues completing this survey? Yes ☐ No ☐
If yes, Please advise how we may help……
Is there any other information the young person would like our reception staff to be aware of, so we can make them feel comfortable?

MANDATORY INFORMATION RQUIRED - PLEASE PROVIDE

Emergency Contact Name……Relationship to young person……
Address……Contact Number……..
If you are the young person, do you consent to:
This referral being made? Yes ☐ No ☐ Your details to be stored on our electronic data base? Yes ☐ No ☐

Young Person's Signature: ……

If you answered no to any of these questions, please speak to one of our Client Service Officers – thanks

(Section B) Referrer Details

Please note: **headspace** is a voluntary service and therefore the young person ***must*** agree to be referred to **headspace**

Has the young person agreed to receive a service at **headspace**? Yes ☐ No ☐

What is your relationship to the young person you are referring?
Parent ☐ Family Member ☐ Friend ☐ Case Worker ☐ Other ☐ specify……...

Is the young person aware that their details will be stored in our electronic record system? Yes ☐ No ☐

Referrer Name……Contact Number……

Agency (If applicable)……

Please list any agencies involved with the young person (that you are aware of)……..…….....

Please specify who you would like **headspace** to contact initially in relation to this referral?
The referrer (me) ☐ The young person directly ☐ Both ☐

Have you completed a **Safety Plan** with the young person in the last 6 months? Yes ☐ **(provide Copy with referral form)** No ☐

Referrer Signature……Date……..……

headspace assists young people with mild to moderate mental health concerns

Please Note: headspace Gosford and **headspace** Lake Haven are not acute mental health services. If you have any *immediate concerns* for the safety of a young person, please call the Mental Health Line on 1800 011 511 or take them to your local emergency department.

Once a referral form has been received, you will complete an intake with a clinician, and an appointment may be booked for you. You can make a request for a member of the Youth Access Team Worker to call you prior to your appointment. Please note that all calls from **headspace** will be displayed as a private number on your phone, therefore we would appreciate if you could answer wherever possible. Thank you.

(Office Use) Entered By:_____ Date:_____/_____/_____ Time: _____ File No._____