

headspace Grafton Referral Form

# Please fax to (02) 6642 7391 or

email to hgreferrals@healthvoyage.org.au

**CLEAR PAGE 1**

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| headspace Grafton is not a crisis service.headspaceGrafton provides early intervention for young peopleaged 12 – 25 years (inclusive) experiencing, or at risk of experiencing, mild to moderate mental health concerns.Referrals will be reviewed by the headspaceGrafton Youth Access Clinical Team and the preferred contact person (page 1) will receive a 1st Connect phone call within 5 working days.For all immediate mental health concerns, please call**Mental Health Access Line: 1800 011 511****Kids Helpline: 1800 551 800**  |

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| **Date of referral / /**day month year | Has the young person been a client at headspaceGrafton before?Yes No Don’t know |
| Has the young person agreed to this referral? Yes No (consent of the young person is **required**) |
| If the young person is under 16 years, are the parents/carers aware of referral? Yes No N/A |

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| **Details of Young Person** |
| Name: | Preferred name: |
| Date of birth: | Age: |
| Address: |  | Homeless |
| Phone: | Can we use this number to SMS appointment reminders? | Yes |   No |
| Email: |
| Gender Identity: | Birth sex: | Female Male |  |  |
| Aboriginal or Torres Strait Islander (TSI): | Aboriginal | TSI | Both | Not Indigenous |  |  |
| Is the young person a student? Yes | No | School / University and year: |

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| **Preferred Contact Person for triage or initial appointment booking (phone call)** |
| Name: | Relationship to young person: |
| Address: |
| Phone: |

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|  | **CLEAR PAGE 2** |
| **Details of Referrer (if you have referred yourself, please write “self” in this section.** |
| Referred by (Name): |
| Relationship: | Organisation: |
| Address: |
| Phone: | Fax: |
| Email: |

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| **Additional Supports** |
| **Does the young person have a regular GP?** Yes No Unknown |
| GP Name and Practice details: |
| Does the young person have a mental health care plan? Yes (please attach) No Unknown |
| Is the young person engaged with any other services? **Please circle/highlight any that apply.** School counsellor, psychiatrist, paediatrician, disability support, housing, employment service, dietitian, psychologistother (please provide detail) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Please describe the reasons for the referral below, including behaviours, feelings, actions, anything of concern.**  |
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## Type of service(s) needed:

Mental Health

Physical Health

Drug and Alcohol

Vocational Support

Sexual Health & Wellbeing

 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Thank you for completing this referral

Please fax to 02 6642 7391 or email to hgreferrals@healthvoyage.org.au Referrals are reviewed by the headspace Grafton Youth Access Clinical Team

within 5 working days of receipt and the preferred contact person (page 1) will be contacted.