headspace Griffith is a voluntary service for young people aged 12 -25 years. headspace can only engage with the young person if they have consented to the referral. Please ensure all sections are completed and legible.

If the young person is experiencing current;

- **Suicidal thoughts**
- **Suicidal Plan**
- **Suicidal Intent**
- **Please contact Accessline on 1800 800 944 or 000 instead of making this referral as headspace Griffith is not a crisis service.**

OFFICE USE ONLY:
Date of Referral: _____
Taken by : _____
File No.: _____

Does the young person consent to provide the following information to headspace and it being stored in headspace's client managment system and hAPI ☐ Yes ☐ No

If the young person is under 14 years of age, have the parents or carers of the young person consented to the referral as well? ☐ Yes ☐ No

YOUNG PERSONS INFORMATION

First Name: _____ Last Name: _____

Preferred Name: _____ Birth Date: _____

Country of Birth: _____ Nationality/Cultural background: _____

Do they identify as Aboriginal/ Torres strait Islander? ☐ Yes ☐ No

Gender: ☐ Male ☐ Female ☐ Other Pronouns: _____

Address: _____ Suburb: _____ Postocode: _____

Email: _____ Mobile Phone: _____

EMERGENCY CONTACT: (we will contact this person if we are concerned about the young person's safety)

First Name: _____ Last Name: _____

Preferred Name: _____ Relationship to young person:

Nationality/Cultural background: _____ Interpreting Service Required?: ☐ Yes ☐ No

Address: _____ Suburb: _____ Postocode: _____

Email: _____ Phone (Business Hours): _____

DETAILS OF REFERRER: (please ensure this section is completed) Please tick if same as above ☐)

Name of referrer: _____ Organisation: _____

Address: _____ Suburb: _____ Postocode: _____

Email: _____ Phone (Business Hours): _____

Mobile Phone: _____ Relationship to young person: _____

REASON FOR REFERRAL

☐ Wellbeing & Mental Health ☐ Alcohol & Other Drugs ☐ Psychology Services

☐ General or Sexual Health ☐ Work, School, Study

MAIN REASON FOR REFFERAL:

RELEVANT PAST HISTORY :

IS THERE ADDITIONAL INFORMATION HEADSPACE GRIFFITH SHOULD BE AWARE OF SUCH AS:

Discharge Summary ☐ Yes ☐ No

Court Orders (AVO's, Parental Orders etc): ☐ Yes ☐ No

Previous relevent reports or assessments such as paediatriac/psychiatric letters, school reports, or NAPLANs

IF YES PLEASE SUPPLY TO

enquiries@headspacegriffith.org.au

1/26 Ulong Street Griffith NSW 2680 T: 02 6962 3277 E: enquiries@headspacegriffith.org.au

headspace National Youth Mental Health Foundation is Funded by the Australian Government Department of Health ABN 7261040348

Does the young person currently see any other services? ☐ Yes ☐ No

If Yes pleas tick appropriate box/boxes

☐ Drug & Alcohol ☐ Child protection ☐ School/ Other Counsellor ☐ Child/ Adolescent Mental Health

☐ Adult Mental Health ☐ Corrective Services ☐ Allied Health/ Non-Government Support ☐ Specialist Medical Services ((Psychiarist/Peadiatrician etc)

☐ Other - Please Specify

Is the other service/s aware of the referral to headspace Griffith? ☐ Yes ☐ No

Will the other service/s currently involved continue working with the young person? ☐ Yes ☐ No

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DOES THE YOUNG PERSON SEE A REGULAR GP? ☐ Yes ☐ No

Name of GP: _____

Name of Medical Centre: _____

Phone (Business Hours): _____

Email: _____

OFFICE USE ONLY:

REFERAL ADDITIONAL NOTES