headspace is an early intervention mental health service for young people aged 12 – 25 years old. Our team will review this referral within 2 working days and will contact the young person to start planning their work together.

Privacy and confidentiality - your information is protected in accordance with the Privacy Act 1988. For further information visit [www.anglicarewa.org.au/privacy](https://www.anglicarewa.org.au/privacy)

*headspace is not a crisis response service. If immediate action is required, please consider crisis support options.*

**You can also complete this referral over the phone by calling 1800 290 626.**

|  |
| --- |
| **Request for support** |
| I am completing this referral for:  myself  on behalf of a young person |
| If completing on behalf of a young person: Do they consent to this referral?  yes  no |

|  |  |
| --- | --- |
| **Young person’s details** | |
| First name: | Last name: |
| Preferred name: | Pronouns**:**  she/her  he/him  they/them  self-describe: |
| Gender:  female  male  non-binary  self-describe: | Date of birth:       /       /       *(DD/MM/YYYY)* |
| Preferred language: | Is an interpreter required:  yes  no |
| Is the young person Aboriginal or Torres Strait Islander?  yes, Aboriginal  yes, Torres Strait Islander  yes, both  no  unsure  prefer not to say  Language group: | |
| Address: | |
| Phone number: | Email address: |
| Contact preference:  phone call  SMS  email | |

If you are completing this form on behalf of a young person, their involvement is important. We kindly require that their consent is provided by signing the next page.

|  |  |
| --- | --- |
| **Referrer details** | |
| Referrer’s name: | Date of referral:       /       / |
| Referrer phone number: | Referrer email: |
| Relation to young person: | Permission to contact referrer?  yes  no |

|  |  |
| --- | --- |
| **Emergency/next of kin contact details** | |
| Contact name: | Contact number: |
| Relationship to young person: | Permission to contact about appointments?  yes  no |

|  |
| --- |
| **Risk/safety concerns** |
| **I am at immediate risk of harm to myself or others:  yes  no**  If no, are you concerned about your safety/wellbeing?  yes  no  *If you ticked yes and require immediate action, please consider crisis support options (000) as headspace is not a crisis service.* |
| Please indicate:  self-harm  suicidal ideation  suicide attempt  violence/aggression  psychosis/mania  substance use/abuse  abuse/neglect  overcrowding/homelessness  court orders/VROs |
| Please tell us a little more: |

|  |  |
| --- | --- |
| **Further information** | |
| I am wanting support with: *(please tick all that apply)* | |
| feeling down, stressed or anxious  emotion regulation (e.g., issues controlling anger)  alcohol or other drug use  work or study  physical health issues  sexual health (e.g., contraception & sexual health checks) | relationship issues including friends/family  sexuality or gender identity  issues with bullying or harassment  isolation  self-harm  body image and/or eating concerns  other: |
| Please tell us a little more: (*e.g., what are your wellbeing goals?)* | |

|  |  |  |
| --- | --- | --- |
| **Young person consent** | | |
| Name: | Signature: | Date:        /       / |

If you are under 16 years old, consent to be provided by parent / guardian / carer:

|  |  |  |
| --- | --- | --- |
| **Legal guardian consent** | | |
| Name: | Signature: | Date:        /       / |

Please save the completed form and email a copy to headspace Pilbara at: [info@headspacepilbara.org.au](mailto:info@headspacepilbara.org.au)

Please attach any other supporting documents that may be relevant.