headspace Horsham

Client Details (these details will be used to contact the young person)

First Name bvbvbvc Surname _____

DOB _____ Age _____

Gender ☐ Male ☐ Female ☐ Other

Does this person identify as Aboriginal or Torres Strait Islander ☐ Yes ☐ No

Address _____

Suburb _____ Post Code _____

Home Phone _____ Mobile _____

Email Address _____

Lives with _____ Relationship _____

Preferred Contact Person _____ Phone _____

Is the young person aware of the referral and wanting services from headspace Horsham?

☐ Yes ☐ No

Reason For Referral

☐ Counselling Services ☐ GP Services ☐ Assessment of Vocational Needs

☐ Alcohol/Drug ☐ Groups

☐ Other _____

Referrer Details (person completing this document)

Contact Name _____ Position/Relationship _____

Organisation (if applicable) _____

Postal Address _____ Post Code _____

Phone _____ Fax _____ Mobile _____

Email _____

Preferred Delivery Method of Progress Reports ☐ Fax ☐ Post

Authorisation of Referral by Person Being Referred

I am aware that this referral is being made.
I understand that I can withdraw from this referral or from the referred service at any time.
I give permission for headspace Horsham to use my contact details above for future contact with me.
I give permission for headspace Horsham staff to obtain further information relevant to this referral.

Signed _____ Print Name _____ Date _____

If the young person is under 18 years of age, consent should be provided by a parent/guardian (if possible and/or appropriate):

Parent/Guardian Signed _____ Print Name _____ Date _____

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1. Presenting Issues

- ☐ Anxiety
- ☐ Refusing School
- ☐ Depression
- ☐ Self Harm
- ☐ Harm/Threats to Others
- ☐ Stress
- ☐ Suicidal
- ☐ Pending Legal Matters
- ☐ Difficulty Sleeping
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ Pain Management Issues
- ☐ Family Problems
- ☐ Other _____

- ☐ Physical Abuse
- ☐ Relationship Issues
- ☐ Low Self Esteem
- ☐ Domestic Violence
- ☐ Emotional Abuse
- ☐ Hallucinations & Delusions
- ☐ Eating Problems
- ☐ History of Hospitalisation
- ☐ Presentation to Hospital
- ☐ ADHD/ADD
- ☐ Financial Difficulty
- ☐ Loss of Appetite
- ☐ Physical Disability

- ☐ Sexual Abuse
- ☐ PTSD/Trauma History
- ☐ Social Problems
- ☐ Aspergers/Autism
- ☐ Body Image
- ☐ Bullying Others
- ☐ Crying
- ☐ Past/Present Contact with Child Safety
- ☐ Previous Incarceration or Criminal History

2. Risk

	Low	Medium	High	Comments
☐ To Self	☐	☐	☐	
☐ To Others	☐	☐	☐	
☐ By Others	☐	☐	☐	

3. Other Agencies/Health Care Providers Currently Involved in the Young Persons Care Presenting Issues

4. What Do You Hope headspace Horsham can Achieve For This Client

5. Summary Of Young Person