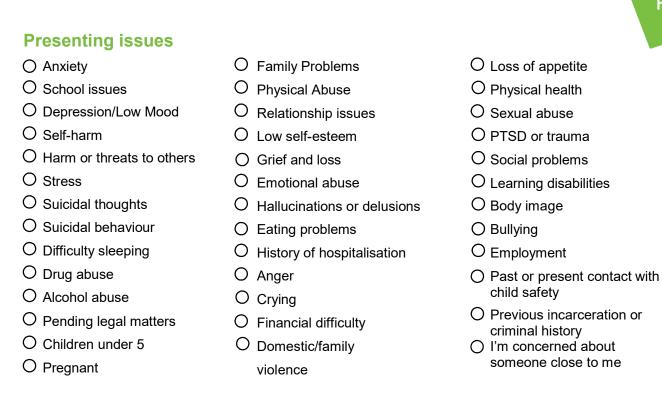


Details of young person

| First name | Surname | | | | | |
|--|---------------------|-----------------|-----------|---------|----------|--|
| Preferred name | Date of Birth | | | | | |
| Gender O male O female O trans male O trans | female O gender i | neutral O non | -binary | | | |
| Pronouns O he him his O she her h | ers O them th | eir theirs | | | | |
| Language other than English? Is an interpreter require | ed? | | | | | |
| Does this person identify as Aboriginal or Torres Strai | t Islander? | 0 | Yes | 0 | No | |
| Address | | | | | | |
| Suburb/town | Post Cod | e | | | | |
| Email | Mobile | | | | | |
| Medicare # | Reference # | E: | xpiry | | | |
| Are there any alerts in regards to this referral that we s home, etc) | hould we aware of? | (i.e. no parent | contact, | no lett | ers - | |
| Other contact details | | | | | - | |
| O emergency contact O next o | of kin | O preferr | ed contac | t pers | on | |
| Name | Mobile | | | | | |
| Relationship to young person | | | | | | |
| Service delivery method O face to face O Telehealth O phone O appoint at school, what school do you attend: Details of referral (Primary reason for referral) O mental health O drug and alcohol O O other | vocational O | | | group |)S | |
| Details of referrer (person completing the second s | nis document) | | | | | |
| Name Relationshi | p to young person _ | | | | | |
| Organisation (if applicable) | | | | | | |
| Phone Email | | | | | | |
| Additonal referral details | | | | | | |
| Does the young person have a mental health care plan? O Yes O No Does the young person have an NDIS plan? O Yes O No Will you or another person from your service (if applicable) have continued | | | | | | |
| involvement with this young person? | bie) have continued | () Yes | () No | | | |
| Has the young person agreed to this referral? Is the young person currently involved in other support If so, what are they (this includes GP, community servi | | ŌYes | Ŏ № | | | |
| | | | | | | |



Risk

| | NIL | Low | Medium | High | Comments |
|-----------|-----|-----|--------|------|----------|
| To self | 0 | 0 | 0 | 0 | |
| To others | 0 | 0 | 0 | 0 | |
| By others | 0 | 0 | 0 | 0 | |

Please summarise the young person and what you hope headspace Horsham can achieve for them. Feel free to also add any relevant information not yet covered.

Important information about your referral

headspace is a service for young people aged 12-25. We can only engage with young people who are happy and willing to engage and who have provided consent to the referral.

headspace Horsham is <u>not</u> a crisis service. Please contact emergency services 000 if the young person is in crisis or at acute risk of harming themselves or others. In a mental health emergency please contact the Mental Health Service 24-hour call line 1300 661 323.

To provide a complete referral email to <u>info@headspacehorsham.org.au</u>. We will endeavour to respond to referrals within 24-48 business hours, but if you have any queries please phone us on 5381 1543.

In agreeing to this referral, the young person is aware that they may withdraw from the referral or services at headspace Horsham at any time and we will use their contact details above to make future contact directly with them. Referrals will not be accepted without the consent of the young person.