headspace Inala Referral Form

This form collects information relating to the child/young person and their parent/carer and confirms the details provided by the referrer. By completing this form, you agree to general collection, use and storage by Accoras.

Please read before submitting your referral

- headspace Inala is a voluntary service that provides free mental health and wellbeing support for **young people aged 12–25.**
- The young person must know about this referral and agree to being referred. If the young person has not consented, headspace Inala may not be able to proceed with the referral.
- headspace Inala is not an emergency or crisis service. If the young person is at immediate or high risk of suicide, self-harm or harm to others, please call 000 or take them to the nearest hospital emergency department.
- An acknowledgement email means we have received the referral. It does not mean the referral has been accepted.
- headspace Inala will review the referral to determine whether the service is suitable for the young person's needs. If the referral is not suitable, we will let you know and, where possible, provide information about more appropriate services.
- We aim to respond to referrals within 3 business days.
- headspace Inala is fully wheelchair accessible.

Referral Date		**Referring Organisation**	
Referrer Name		**Relationship to young person**	
Referrer Signature		**Referrer Contact Number**	
Referrer Email			

Information Sharing

Please confirm:

☐ The young person knows this referral is being made and has agreed to be referred to headspace Inala.

☐ The young person has given permission for you to share the information in this referral form with headspace Inala so the referral can be reviewed.

A separate consent form will be provided to the young person and explained during the intake appointment. This will cover ongoing information sharing after the referral stage.

Primary Reason(s) for Referral: *This section must be completed*

☐ Short Term Mental Health Intervention
☐ Drug and/or Alcohol Support
☐ Vocational Support (Work and/or Study)
☐ Physical Health Support
☐ Other:

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Young Person's Details			
First/Birth Name		**Last Name**	
Preferred first name		**Date of Birth**	
Gender Identity		**Assigned Sex at Birth**	
Pronouns	☐ he/him ☐ she/her ☐ they/them ☐ Others:_____		
Street Address			
Suburb		**Postcode**	
Contact number			
Email address			
Country of birth		**Ethnicity**	
Interpreter required?	☐ No ☐ Yes If yes, language of interpreter:		
Does the young person identify as an Aboriginal or Torres Strait Islander Person?	☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, Aboriginal and Torres Strait Islander ☐ No		

Parent or Carer Details (if applicable): *Please note that if the young person is aged 16 or under, we will require a parent or legal guardian to be documented on this form and attend the first appointment. This is also a voluntary service and parent/guardian consent is mandatory for us to start working with the young person below the age of 16.*

Full name			
Relationship to young person			
Street Address			
Suburb		**Postcode**	
Contact number			
Email address			

Do we have permission to speak with this person: ☐ Yes ☐ No

Who is the best contact for appointment bookings?

☐ Young Person ☐ Parent/Guardian ☐ Other (fill below)

Name: Contact Number: Relationship to young person:

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Presenting Issues

Current Presenting Issues *(Please include duration, age of onset and any other relevant information)*

Any impact on functioning? *(e.g.: relationship/school/home/work/decline in function)*

Any known family history of mental health conditions?

Any previous/current engagement with other services? *(please list all organisations)*

Consent given to contact other services: ☐ Yes ☐ No

Risk Factors

☐ Suicide Attempt/s

☐ Suicidal Ideation

☐ Homelessness

☐ Non-Accidental Self-Injury

☐ Substance Use

☐ Depression

☐ Harm to Others

☐ Misadventure

☐ Withdrawal

☐ Eating Disorder

☐ Anxiety

☐ Other: _____

Please provide further details below:

headspace Inala Referral Form

Crisis information

If the young person is in distress or at immediate risk of harm (or harming someone else), call 000, or present with them to the closest hospital emergency department. headspace Inala is not an emergency or crisis service and does not provide after-hours support.

- eheadspace 1800 650 890
- Lifeline 13 11 14
- Beyond Blue 1300 22 4636
- Kids Helpline 1800 55 1800
- Suicide Call Back Service 1300 659 890
- Mental Health Access Line 1300 64 22 55

Please email this form to headspace Inala at headspaceinala@accoras.org.au

We will acknowledge your referral within three working days

For any non-urgent questions, please email us, or call (07) 3727 5000