headspace referral form

Please return to:
Email: headspace.indooroopilly@openminds.org.au
Phone: (07) 3157 1555 **Fax:** (07) 3870 7405
Address: Level 1, 17 Station Rd, Indooroopilly QLD 4068

Important information regarding your referral, **please read:**

- headspace Indooroopilly is a service for young people between the ages of 12 to 25. We can only engage with young people who have provided consent to the referral.
- If the young person is at high or acute risk of suicide, please contact emergency services on 000.
- Please note that receipt of the referral form does *not* indicate acceptance to the headspace Indooroopilly services. Suitability of the referral will be determined following assessment with the young person.
- To complete the referral, you must attach relevant assessment notes, discharge summaries and/or additional information.
- We will endeavour to respond to referrals within 2-3 business days.

Date of Referral:

Consent for Referral

Has the young person consented to and provided permission to exchange information in relation to this referral?	☐ Yes ☐ No

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

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

Young Person's Details:

First Name: Surname: Age:
Preferred Name: D.O.B:
Gender Identity:
Address:
Suburb: Postcode:
Contact Number (1): Contact Number (2):
Email:
Interpreter Required: ☐ Yes, Language: ☐ No
Assistance with reading/writing? ☐ Yes ☐ No
Is the young person of Aboriginal or Torres Strait Islander origin? ☐ Yes

Referrer Details: headspace will be corresponding with you using the below details. Please ensure that all details listed below are correct and legible.

Name of Referrer: Organisation:
Role/relationship to Young Person:
Contact Number: Fax:
Referrer email address:

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Parent/guardian: Please note that if the young person is aged 16 and under, we will require a parent or legal guardian to be documented on this form and attend the first appointment.
Name:
Relationship to young person:
Contact Number:
Do we have permission to speak with this person: ☐ Yes ☐ No
Who is the best contact for appointment bookings? ☐ Young Person ☐ Parent/Guardian ☐ Other: Name: Relationship to young person: Contact Number:
Presenting Issues:
Current Presenting Issues (Please include duration, age of onset and any other relevant information)
Impact on functioning (e.g.: relationship/school/home/work/decline in function)
Known family history of mental health conditions
Previous/current engagement with other services: (please attach all relevant assessment/notes)

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Risk Factors
☐ Suicide attempt(s) ☐ Suicidal Ideation ☐ Homelessness ☐ Non-Accidental Self-Injury ☐ Substance use ☐ Harm to Others ☐ Misadventure ☐ Social Withdrawal ☐ Other **Please provide further details below:**
Referrer's Name: **Referrer's Signature:** **Date:** *By signing this document, the referrer agrees that the above information is a true and accurate record*