

Referral Guidelines

About headspace Kalgoorlie

headspace Kalgoorlie is a free, youth-friendly and confidential service for young people aged 12 – 25 years. Lead by Hope Community Services, **headspace** Kalgoorlie, brings together a range of services, to provide a holistic "one-stop-shop" for young people. We offer information, intake, assessment and referral. **At headspace** Kalgoorlie we offer the following supports and services including:

- Youth Friendly General Practitioner Walk-In GP Service Tuesdays 10am – 2pm
- Youth Counselling
- MBS & ATAPS Psychological Services
 (Under GP Mental Health Treatment Plans)
- Support Groups Young Parents Significant Others Homework Club

Telepsychiatry Service

Alcohol & Drug Education Counsellors

• Youth Career Guidance Support

PLEASE NOTE:

headspace Kalgoorlie is not an acute mental health/crisis service. If you have any immediate concerns regarding the safety/wellbeing of a young person, please call: Mental Health Emergency Response Line (MHERL) on 1800 555 788; Lifeline on 13 11 14; or Kids Helpline on 1800 55 1800. In an emergency, contact 000 immediately.

HOW TO REFER:

Self-Referral

Young people are encouraged to make contact with the headspace Kalgoorlie service directly.

By phone/email

Call (08) 9021 5599 within office hours or email hKalAdmin@hopecs.org.au, a worker will contact the young person to make an appointment within 1 – 3 working days.

Drop in

Young people can call into **headspace** Kalgoorlie, Level 1/48 Brookman Street, Kalgoorlie, between 10am and 5pm, Monday – Friday. Staff will endeavour to see the young person the same day or the next available appointment will be offered.

Professional Referral

GP's, Allied Health Professionals, community-based agencies and educational institutions can all refer young people to **headspace** Kalgoorlie using the Referral Form attached. General Practitioners should include a mental health care plan (if appropriate) for the young person and attach this to the **headspace** Kalgoorlie referral form.

Family Referral

Families, carers or friends can refer a young person to **headspace** Kalgoorlie. The young person needs to be aware of and consent to the referral and be willing to meet with a member from the **headspace** Kalgoorlie team. Once receipt of referral has been confirmed, a worker will contact the young person within one to three working days to make an appointment. Families, parents or carers who have a young person engaged with **headspace** Kalgoorlie can also access our centre to discuss service provision.

For more information regarding **headspace** Kalgoorlie, please contact us directly or visit our website at <u>www.headspace.org.au/kalgoorlie</u>.



PLEASE COMPLETE BOTH SIDES OF THIS FORM

Date of Referral:			Is client aware of referral?	🗆 Yes 🗆] No		
Referral Type:	□Walk in □Phone □Email □ Fax		Self Doctor:				
		Referral	□School □Friend/Family Member				
		Source:	Service Provider:				
Client Details							
Name:			DOB:				
Address:		Gender	 □ Male □ Gend □ Female □ Indet □ Other: 	erminate			
Mobile:		Email:					
Medicare Number:		Reference:		Expiry:			
Do you suffer from any of the following health conditions?							
□ Diabetes □ Heart Disease □ Epilepsy □ Lung Disease □ Allergies:							
Emergency Contact Details							
Name:		Phone:					
Address:		Email:					
Relationship:		Can we contact this pe appointments?		it your	🗆 Yes 🛛 No		
Referrer's Details							
Referrer's Deta	ils: \Box Same details as I	Emergency Con	tact				
Name:		F	Relationship:				
Address:		(Organisation:				
Phone:		Email:					
Can we contact this person about your appointments? Yes No							
Reason/s for Referral:							
Can you tell us a little more?							



Client Consent						
•	A part of the referral process to headspace Kalgoorlie is for us to learn about you and the other services involved in your life.					
•	 All information we find out about you, including from the HAPI (iPad) survey, will be treated confidentially, which means we will not share your information with anyone else unless you give us permission or you are at serious risk. 					
 I am involved in the following services and I consent (give my permission) to headspace Kalgoorlie to obtain the relevant information from the following people: 						
\Box CAMHS (Child and Adolescent Mental Health Service) \Box CMHS (Commu			nity Mental Health Service)			
	GP – Name:	Not For Profit:	Not For Profit:			
	Practice:					
□ High School Psychologist/Chaplin/Counsellor:		Primary School Psychology	Primary School Psychologist/Chaplin/Counsellor:			
		School:	School:			
Name: Name:						
□ Government Service: □ Anyone else you can think of?						
Department of Child Protection and Family Support						
Youth Justice						
Department of Corrective Services (Police)						
	 I am aware that this referral is being made headspace Kalgoorlie at any time. 	□ Yes □ No				
 I understand that any information collected by headspace is stored confidentially. I give my permission for headspace Kalgoorlie to obtain relevant information from the people listed above and from the HAPI (ipad) □ Yes □ No survey conducted at the beginning of every appointment. 						
Cli	ent Signature: Client	Client Name: Da				
If the young person is under 16 years of age , authorisation should (where possible) be provided by a parent/guardian/carer.						
Gι	ıardian Signature: Guardi	ian Signature: Guardian Name:				