SELF REFERRAL FORM

For yourself, family or friend…….

STOP Professional referrer Please use 'professional referral form Thanks….

PLEASE RETURN COMPLETED FORM TO:
Address: Cnr Brisbane & Wellington St, Launceston TAS **Phone:** (03) 6335 3100 **Fax:** (03) 6335 3127
Email: headspace@csys.com.au **Website:** www.cornerstoneyouthservices.com.au

Please Note: headspace Launceston is not an acute mental health service or crisis service. If you have concerns for your own or someone's immediate safety please contact the Mental Health Helpline on 1800 332 388. For urgent medical assistance please call: 000.

YOUNG PERSON DETAILS:

Contact details: First Name: _____Last Name:_____

Gender: _____Date of Birth:_____

Address:_____ Post Code: _____

Home Phone:_____ Mobile Phone: _____

Email:_____

Medicare and Centrelink information:
Medicare Card Number _ _ _ _ _ _ _ _ _ _ / _ Ref _ Exp Date _ _ /_ _ /_ _

Do you have a regular Doctor? Name_____Medical Practice_____

Do you have a Health Care Card or Pension Care? YES/NO

Centrelink Reference Number _ _ _ _ _ _ _ _ _ _ / _ Expiry Date _ _ / _ _ / _ _

Are you Aboriginal or Torres Strait Islander? YES/NO/BOTH (Please Circle)

Do you require an Interpreter YES/NO (please circle) Preferred Language_____

Are you under any Legal or Guardianship orders YES/NO _____

Supports:
If under 16 are your parents / carers aware of this referral? YES/NO (please circle)
Do you currently access any other support organisations? YES/NO (please circle)
Do you have an NDIS Plan YES/NO (please circle)
Do you have a current Mental Health Care Plan YES/NO (please circle)
Is there a Family Member or worker you would like us to speak to? YES/NO (please circle)

Name_____Phone/Mob_____
Relationship to you?_____

Emergency Contact / Next of Kin <u>MUST BE OVER 18</u>:

First Name_____Last Name_____

Relationship to You _____Phone_____

REFERRER INFORMATION: (if a family member / carer / friend has completed this form)

Name: _____Relationship to Young person: _____

Phone Number: _____Email_____

Is the young person aware of this referral? YES / NO (please circle)
<u>Please note we are unable to make contact with them if No</u>.

REASON FOR CONTACTING headspace Launceston:

Please tell us the main issues that bring you to headspace Launceston *Greatest problem

Health: Are there any general health issues limiting your day to day or social activities? YES / NO

Drug and Alcohol: Are drugs and/or alcohol having a negative impact on areas of you health or lifestyle? YES/NO

Education and Training: Do you require support with education, training and/or employment
YES / NO

<u>Whats Next?</u>

We will attempt to make phone contact with you to discuss the referral further. Please put our phone number 63353100 into your contacts so you know who is calling you.
If we have any problems getting in contact with you we may follow up with an email or letter.

PRIVACY: Your privacy is important to us. This info will be kept confidential and used only to give you the best care possible. Have you read the headspace 'Just between us 'confidentiality statement? YES/ NO (Please circle)

Signature_____ Date_____

Office use only: Admin Signature Date__ /_ _/__ Time _ :_ am/pm