

Referral Form

headspace Mackay, headspace Sarina, and headspace Whitsundays are not acute mental health/crisis services. If you have any immediate concerns regarding the safety/wellbeing of a young person, please have them attend Mackay or Whitsundays Community Mental Health or call 1300 642 255. In an emergency, contact 000 immediately.

Please Note – we will be unable to accept the referral if the below section is blank.

Is the young person currently at risk to self or others by self-harming, or having suicidal thoughts with plan or intent?

Yes – Describe: _____ No

Preferred Centre:

headspace Mackay

headspace Sarina

headspace Whitsundays

The organisation that manages headspace Mackay, Sarina and Whitsundays is North and West Remote Health.

Person being referred (These details will be used to contact the young person/parent/guardian)

Reason for Referral

Mental Health Alcohol/Drug Use Physical Health Vocational Support Group Other

Date of Referral:

First Name:		Last Name:	
Preferred Name:		Pronouns:	
Date of Birth:		Gender Identity:	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Agender <input type="checkbox"/> Non-binary <input type="checkbox"/> Trans woman <input type="checkbox"/> Trans man <input type="checkbox"/> Gender Fluid <input type="checkbox"/> Sistergirl <input type="checkbox"/> Brotherboy <input type="checkbox"/> Gender Questioning <input type="checkbox"/> Prefer not to answer
Ethnicity:	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Aboriginal & Torres Strait Islander <input type="checkbox"/> South Sea Islander <input type="checkbox"/> Not Applicable <input type="checkbox"/> Other		

Do you have a preference to see a male or female clinician? Male Female No Preference

**Please note we will try our best to accommodate this request however due to staff availability this may not always be possible*

Young person mobile number:		Parent/Guardian Name:	
		Parent/Guardian Contact Number: <small>(if consent given by young person)</small>	
Young Person Email:		Parent/Guardian Email Address:	
Home Address:			
	<input type="checkbox"/> No Fixed Address		

Consent to Referral by Young Person:

I am aware that this referral is being made and consent to access services. I understand that I can withdraw from the service at any time. I give permission for headspace Mackay/Sarina/Whitsundays & NWRH to use my contact details above, and to obtain relevant information from government and non-government agencies, doctors, and other health professionals specifically relevant to my care whilst being a client of headspace Mackay/Sarina/Whitsundays. **Yes** **No**

Please Note – we will be unable to accept the referral if consent is blank.

Signature of young person:	
Parent/Guardian Signature: <small>If under 18 years of age, authorisation ideally would be provided by a parent/guardian</small>	

Referrer Details:			
Relationship to young person: <i>(e.g., mother, sibling, foster carer etc)</i>			
Or external referrer details:			
Referrer Full name:		Contact number:	
Organisation:		Position:	
Email address:			
Presenting Concerns			
<input type="checkbox"/> DEPRESSION		<input type="checkbox"/> NDIS	
<input type="checkbox"/> ANXIETY		<input type="checkbox"/> PENDING LEGAL MATTERS	
<input type="checkbox"/> ALCOHOL/DRUG MISUSE		<input type="checkbox"/> TRAUMA	
<input type="checkbox"/> AUTISM(ASD)		<input type="checkbox"/> BODY IMAGE/SELF-ESTEEM	
<input type="checkbox"/> ADHD/ADD		<input type="checkbox"/> EATING CONCERNS	
<input type="checkbox"/> ANGER		<input type="checkbox"/> FAMILY/RELATIONSHIPS CONCERNS	
<input type="checkbox"/> BULLYING/SCHOOL REFUSAL		<input type="checkbox"/> SEXUALITY/GENDER IDENTITY	
Notes (about the boxes ticked above):			
Please Note – we will be unable to accept the referral if the box below is left blank			
Eligibility Criteria:			
<ul style="list-style-type: none"> • General Practitioners – Please note headspace does not require a mental health care plan to refer a young person; however if the young person does have a current MHCP, please attach a copy to this form. • Referrals from CYMHS/QLD Health or other service providers - Please provide a copy of all relevant documentation (including assessment, treatment and discharge summaries) prior to referral being processed • Referrals from Youth Justice/Probation & Parole – Please provide information on convictions and pending legal matters (including dates, along with AOD information) prior to referral being processed 			
Sending your referral:			
headspace Mackay Please email referral to: Mackayheadspace@nwrh.com.au Or fax to: (07) 4898 2299 For more information please call: (07) 4898 2200			
headspace Sarina Please email referral to: Sarinaheadspace@nwrh.com.au Or fax to: (07) 4898 2299 For more information please call: (07) 4842 6750 <i>*Please note the centre is open Mondays, Tuesdays, and Wednesdays</i>			
headspace Whitsundays Please email referral to: Whitsundaysheadspace@nwrh.com.au Or fax to: (07) 4898 2299 For more information please call: (07) 4842 6760 <i>*Please note the centre is open Mondays, Tuesdays, and Wednesdays</i>			