Client Consent to service and collect/share information

Welcome to headspace. headspace Mackay, Sarina & Whitsundays are a youth mental health service for ages 12-25 operated by lead agency North and West Remote Health and funded by Northern Queensland Primary Health Network. In providing you with our services, it is necessary for us to collect some of your personal or sensitive information to provide you with a high quality of service. Privacy and confidentiality of your information is important to us.

We are required to report unidentifiable information about you (age, number of sessions, gender) to our funding body NQPHN and to headspace National for research and quality improvement purposes. When you complete your hAPI survey on our iPad, you are providing important information for us to continue to improve our services to young people. Please read this document carefully. When you sign below, you consent to us collecting your information and using this to:

- Provide you with health care under core streams of mental health, physical health, alcohol and other drugs, and vocational support.
- Improve your access to headspace health care services.
- Improve your journey through the health care system.

This may include:

- Using your information to talk with you about, or organise your health care
- Using your information to diagnose or treat a health condition in consultation with other health professionals e.g., Community Mental Health, GP's, Paediatricians, Psychiatrists, Schools, and others
- Sharing relevant information with appropriate staff, specialists, and other healthcare providers as necessary to determine the best course of treatment or to provide services (if you are seen under a mental health care plan, some of your information may be passed onto Medicare)
- Using your information to improve the services we provide.
- Using de-identified information for reporting or training purposes to the funding body NQPHN and headspace National.
- Using or disclosing your information as required by law, or justified by permitted general situations and permitted health situations in the Australian Privacy Principles (for example, if there is a concern that you or another person is at risk of harm; or if the case files are subpoenaed by court)

I, *(Young person full name)* _____.

authorise headspace to share/receive information relating to my health and wellbeing with the following entities, where relevant or necessary. Please tick and provide details below.

☐ **Community Mental Health (Queensland Health)**

☐ **GP: *(Practitioner name)*** _____ of

(Practice name) _____.

☐ **School/TAFE/University *(Name of Institution)*** _____.

☐ **Other: *(Practitioner name)*** _____ of

(Organisation Name) _____.

Consent of Young Person:

The details we collect will only be used for the above reasons. To correct or access any information kept about you by headspace and lead agency NWRH, or to make a complaint, please speak with our staff or complete a feedback form. We manage your personal information in accordance with the Privacy Act 1988, the Australian Privacy Principles, our Privacy Policy and all other relevant Government laws and regulations. You can view the headspace privacy policy at https://headspace.org.au/privacy-policy/ or NWRH Policy at www.nwrh.com.au/who-are-we/policies-and-charters/ If we are unable to collect the required information for these purposes, we may be unable to provide or facilitate access to our services on an ongoing basis.

Please tick and complete the below:

☐ **I,** ***(Young person full name)*** _____**,** ***(date of birth)*** _____**,**

of Address: _____ consent to my information being collected, used, and disclosed to headspace and lead agency NWRH or the above entities for the above purposes, and understand that my de-identified information will be provided to NQPHN and headspace National for statistical and quality improvement purposes. I understand there are some circumstances that require my clinician to break confidentiality to keep me or others safe. I understand that headspace is a voluntary service, and I can withdraw consent at any time. I acknowledge that if I have any concerns I can speak to my clinician or the manager, and I have rights and responsibilities in accepting care at headspace. I acknowledge I have received a copy of the Welcome Pack outlining this.

(Young person Signature) _____ ***(Date)*** _____

Parental Consent if under the age of 18 years old.

☐ **I,** ***(Parent/guardian full name)*** _____**,** consent to the above on behalf of

(Young person full name) _____**.**

(Parent/guardian Signature) _____ ***(Date)*** _____

Cancellation Policy

Your appointment at headspace is valuable.

When your appointment is made at headspace, this time is reserved especially for you. We require at least 24 hours' notice of any change or cancellation to your appointment so we can offer that time to another young person, and the clinician has enough time to prepare for this change. We understand that sometimes emergencies or illness does occur, and we will take this into consideration.

If you need to cancel or reschedule your appointment, including a phone or telehealth session, we kindly request that you either call the office within business hours or email us. Please note our site email is not monitored regularly and headspace is not a crisis service. If you require support outside of our business hours, please call the mental health access line on 1300 642 255, or lifeline on 13 11 14. If you require immediate support, please present to the emergency department at Mackay or Proserpine Base Hospital.

headspace has a full schedule of appointments, and missed appointments prevent us from providing treatment to other young people wanting an appointment. To help remind you of your upcoming session, we will send a text message to your mobile number 2 days prior to your appointment.
This message will ask you to confirm that you will be coming to your appointment.

Please note that if you do not attend or cancel your appointment with less than 24 hours' notice on 2 or more occasions, we may not automatically offer further appointments with our service until your ability to attend is assessed by our Youth Access Clinicians. If this occurs, we will offer you a time to speak with our staff. We may also try to get in contact with you via email or post. If we are still unable to contact you within 2 weeks of sending a letter, your current referral may be closed; however, you are always welcome to engage with us in future.

We understand in some circumstances you may feel that your allocated clinician is not right for you. If this occurs, please bring this to the attention of the staff member you feel most comfortable with.
We welcome you to discuss any concerns or difficulties you may have with attending, as our friendly staff can support you to access appropriate care.

Please tick and complete the below:

☐ **I, *(Young person full name)*** _____, have read and understood the above cancellation policy. I am aware of my responsibility to contact headspace if I need to cancel or change/reschedule my appointment. I understand that if my allocated clinician isn't right for me or I am not comfortable, I can speak with the staff to arrange an alternative solution.
(Young person Signature) _____ ***(Date)*** _____

☐ **I, *(Parent/guardian full name)*** _____, have read and understood the above cancellation policy and consent on behalf of
(Young person full name) _____. I agree to contact headspace for the young person if they need to cancel or change/reschedule their appointment. I understand that if the allocated clinician isn't right for the abovenamed young person, I can speak with the staff to arrange an alternative solution.
(Parent/guardian Signature) _____ ***(Date)*** _____

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Client Consent to Telehealth Services

After the effects of COVID-19, we have adjusted our service delivery to offer both phone and video counselling (telehealth) as required. We've taken this step to allow flexibility in the way young people access our services, and to ensure the safety of young people, their family and friends, and staff working in our centres due to emergencies such as COVID. Telehealth allows you to talk to a headspace clinician through a phone or video call if you are unable to see them in person.

Phone and online counselling services are an effective way of supporting young people to understand and manage their mental health issues. For some people, it can be strange at first, however your clinician will help you feel comfortable and become familiar with the process. Phone and online services can be a positive experience, as many people may feel less self-conscious. If you're not comfortable, please let our staff know. Once we understand your challenges, we are much better placed to address them and support you to access sessions in a way that works for you.

To access phone appointments, a mobile or landline is required. For telehealth, you'll need a laptop, tablet, or mobile and internet connection. If you choose this option, a link will be sent to you to access the video call with your clinician. headspace is committed to protecting your privacy and we use systems that meet recommended standards to protect your privacy and security. Please note we cannot guarantee total protection against hacking or tapping into the video consultation by outsiders. The risk is small, but it does exist. There is also a chance that technical problems could affect your phone or video consultation. If this occurs, your clinician will attempt to reconnect, and if unsuccessful, will call your nominated phone number or support person if required.

It's a good idea to test your equipment 15 minutes prior to your appointment to prevent any delays or missing your session. We kindly ask that you find a quiet place in your home or even outside by yourself and where you feel safe and comfortable chatting without distraction. If you can, let your family/friends know that you are on a call and ask for some space. In some cases, we may need to speak with your parent or guardian first to give consent or be involved in the session.

Please tick and complete the below:

☐ **I, *(Young person full name)*** _____**,** have read and understood the telehealth policy. I consent to have video or phone consultations with my headspace clinician if required and am aware of the possible risks associated with telehealth appointments. I am aware of my responsibility to contact headspace if I need to cancel or change/reschedule my appointment.
(Signature) _____ ***(Date)*** _____

☐ **I, *(Parent/guardian full name)*** _____**,** have read and understood the telehealth policy. I consent for
(Young person full name) _____ to have video or phone consultations with their headspace clinician if required and am aware of the possible risks associated with telehealth appointments. I am aware of my responsibility to contact headspace on for the young person if they need to cancel or change/reschedule the appointment.
(Parent/guardian Signature) _____ ***(Date)*** _____

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Registration Forms

This information is to be completed about the young person receiving services

Personal Information			
Title	☐Miss ☐Ms ☐Mrs ☐Master ☐Mr ☐Mx	**Gender Identity**	☐Female ☐Male ☐Agender ☐Non-binary ☐Trans woman ☐Trans man ☐Gender Fluid ☐Sistergirl ☐Brotherboy ☐Gender Questioning ☐Prefer not to answer
Full Name			
Preferred Name		**Pronouns**	
Date of Birth		**Indigenous Status**	☐Aboriginal ☐Torres Strait Islander ☐Aboriginal & Torres Strait Islander ☐South Sea Islander ☐Not Applicable ☐Other _____
Home Address	☐ No fixed address	**Suburb**	
		Postcode	
Postal Address	☐ If same as above, please tick	**Suburb**	
		Postcode	

Please tick below to confirm which number the SMS appointment reminders should be sent to (please pick only one number)

Young Phone Number SMS Reminders ☐		**Young person email address**	
Parent/Guardian 1 Name		**Parent/Guardian 2 Name**	
Parent/Guardian 1 Phone Number SMS Reminders ☐		**Parent/Guardian 2 Phone Number** SMS Reminders ☐	
Parent/Guardian 1 Email:		**Parent/Guardian 2 Email:**	
Relationship to young person *(e.g., Father, Mother, foster carer, sibling)*		**Relationship to young person** *(e.g., Father, Mother, foster carer, sibling)*	
Are there any current custody arrangements, court orders, or alternative information needed			

Health Care			
Name of GP Practice		**Practice Contact number**	
Usual Doctors Name		**Practice Address**	

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This information is to be completed about the young person receiving services

Health Care - continued					
Medicare Card number *(10 numbers at top of card)*		**Reference** *(the number next to your name)*		**Card Expiry Date**	
Health care card number *(if you have one)*		**Card expiry date**			

Emergency Contact			
If emergency contact and next of kin are the same, please tick to avoid writing twice ☐			
Full name			
Contact number		**Relationship to young person** *(e.g., Mother, foster carer, sibling)*	
Home Address		**Suburb**	
		Postcode	

Next of Kin			
Full name			
Contact number		**Relationship to young person** *(e.g., partner, parent, sibling)*	
Home Address		**Suburb**	
		Postcode	

Work, School and Home			
Occupation		**Religion**	
Do you speak another language at home?	☐Yes ☐ No If yes, please list _____	**Do you require an interpreter?**	☐Yes ☐No
Employment Status	☐Full time ☐Part Time ☐Casual ☐Unemployed ☐Seeking employment ☐Other ☐Not Applicable ☐Student ☐Primary Education ☐Secondary Education ☐Tertiary Education		
Education	☐Year 7 ☐Year 8 ☐Year 9 ☐ Year 10 ☐Year 11 ☐Year 12 ☐Certificate ☐Diploma ☐Bachelor Degree ☐ Other _____		
Who do you live with	☐ Both parents ☐ One parent ☐ Both parents -Shared Custody ☐ One Parent & Step Parent ☐ Foster Parents ☐ Sibling/s ☐ Grandparents ☐ Other relatives _____ ☐ Friends ☐ Alone ☐Partner/Spouse ☐Other (please specify)_____		
Living arrangement	☐House/Unit/townhouse/duplex/caravan ☐Public Housing ☐Crisis Accommodation ☐Other ☐Mental Health Service Residence ☐Alcohol/Drug Treatment Residence ☐Homeless Shelter		
How did you hear about us	☐GP/Other Health Professional ☐Brochure/flyer ☐Family/Friend ☐Social Media ☐Website/Internet ☐TV ☐Other		

Kessler Psychological Distress Scale *(K10)*

This form is to be completed by the young person receiving services

Please tick the answer that is correct for you:	**None of the time** (score 1)	**A little of the time** (score 2)	**Some of the time** (score 3)	**Most of the time** (score 4)	**All of the time** (score 5)
1. In the past 4 weeks, about how often did you feel tired out for no good reason?	☐	☐	☐	☐	☐
2. In the past 4 weeks, about how often did you feel nervous?	☐	☐	☐	☐	☐
3. In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐
4. In the past 4 weeks, about how often did you feel hopeless?	☐	☐	☐	☐	☐
5. In the past 4 weeks, about how often did you feel restless or fidgety?	☐	☐	☐	☐	☐
6. In the past 4 weeks, about how often did you feel so restless you could not sit still?	☐	☐	☐	☐	☐
7. In the past 4 weeks, about how often did you feel depressed?	☐	☐	☐	☐	☐
8. In the past 4 weeks, about how often did you feel that everything was an effort?	☐	☐	☐	☐	☐
9. In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?	☐	☐	☐	☐	☐
10. In the past 4 weeks, about how often did you feel worthless?	☐	☐	☐	☐	☐

Total _____

Full Name: _____ **Today's Date:** / /

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