**Date** \_\_/\_\_\_/\_\_\_\_\_\_

**Young Person’s Details:**

**Name of Young Person:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­

**Gender Identity:** \_\_\_\_\_ **Sex assigned at birth**: \_\_\_\_\_ **Pronouns**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_\_

**Do they identify as:** Aboriginal Torres Strait Islander [ ]  Both [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Suburb**: \_\_\_\_\_\_\_\_\_\_\_\_ **Post Code**:\_\_\_\_\_\_\_\_\_\_\_\_ **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mobile**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is the young person currently in crisis or at risk to self or others?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(headspace is not a crisis response service – consider an alternative referral)

**Consent – Has the young person agreed to this referral?** (headspace requires young person’s consent) Yes [ ]

**Contact preferences and availability:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Be specific. Do you attend work or school? Can we call while at school? Do they have a preferred day & time for contact?)

**Consent to contact young person via:**

Text: Yes [ ]  No [ ]  Voicemail: Yes [ ]  No [ ]  Home Phone: Yes [ ]  No [ ]

Mail: Yes [ ]  No [ ]  Email: Yes [ ]  No [ ]  Text Reminders to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is Parent/Guardian/Carer aware that they are accessing support at headspace?** Yes [ ]  No [ ]

(If under the age of 16 years parent/guardian consent is required. Clinician’s will obtain parental/guardian consent)

**Consent for Parent/Guardian/Carer to schedule or cancel appointments?** Yes [ ]  No [ ]

**Emergency Contact** (Over 18 years of age)

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship**: \_\_\_\_\_\_\_\_\_\_\_ **Contact Number:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicare Information** (Optional):

**Medicare #: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ Reference No: \_\_ Expiry Date: \_\_\_\_ / \_\_\_\_\_\_\_**

**Referral requesting**: headspace Centre [ ]  LYRIC (While You Wait) [ ]  Halls Head College Outreach [ ]  John Tonkin College Outreach [ ]  Waroona District High School Outreach [ ]  Austin Cove Baptist College Outreach [ ]  [ ]

**GROUPS: ART THERAPY [ ]  SPRINKLES [ ]**

**PREFERENCE OF COUNSELLOR: M[ ]  F [ ]  Either** [ ]

**Details of Referrer:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency & Role:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE FORWARD ANY AVAILABLE DOCUMENTATION**

Attached: Referral Letter [ ]  Discharge Summary [ ]  Mental Health Plan [ ]  Notes [ ]  Assessment [ ]

Has the YP received assistance from other mental health services prior to this referral? Yes [ ]  No [ ]

Is the YP currently receiving assistance from another mental health service? Yes [ ]  No [ ]  Details of organisation, contact person, phone details and consent to contact

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Have you referred this young person to any other service? Yes [ ]  No [ ]  N/A (please provide details)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presenting concerns (INCLUDE DURATION)

(NB: if young person identifies physical/sexual health concerns, only the 1st page needs to be completed).

Mental Health [ ]  Physical Health [ ]  Sexual Health [ ]  Alcohol and Drugs [ ]  Situational [ ]  Vocational/Education [ ]  Social Support [ ]  Family Support [ ]  Eating [ ]  Home/Environment [ ]  Friendships [ ]  Relationships/Sexuality [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does the Young Person have a GP and is it OK to contact them?** Yes [ ]  No [ ]

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MedicalCentre:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MH diagnosis** (if relevant): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current MHTP? Yes [ ]  No [ ]  Current Medication? Yes [ ]  No[ ]  Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_

Risk Assessment (NB: Include harm to self/others, suicide ideation/attempts, neglect, abuse, homeless, etc.):

|  |  |  |  |
| --- | --- | --- | --- |
| **Date**  | **Risk** | **Identified Trigger** | **Outcome/Treatment** |
|  |  |  |  |

• All referrals will be considered, however if the young person is better suited to an alternative support option headspace Mandurah will attempt to notify the referring agency with the recommendations.

• On receipt of this form, headspace Mandurah will contact the young person to discuss support options available.

• With consent from the young person, headspace Mandurah will advise the referring agency of the young person making an initial appointment.

• If headspace Mandurah is unable to contact the young person, they will notify the referring agency.

• If you need further information, please contact headspace Mandurah on (08) 9544 5900.

• Please forward completed this form and all supporting documentation to headspace Mandurah by email hello@headspaceman.com.au or by fax 086316 3355. • We are unable to provide psychological assessments or reports for another purpose (e.g. in relation to Workers Compensation, Centrelink or Family Court matters).