**Date \_\_/\_\_\_/\_\_\_\_\_\_ Staff \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lumary # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referral source:** Young Person [ ]  Family [ ]  Agency [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral received by:** Phone [ ]  Onsite [ ]  Email [ ]  Fax [ ]

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

**Are you interested in LYRIC** (While You Wait Program)? Yes [ ]  No [ ]

**(If interested, explain what the LYRIC program is to YP/Family etc.).**

**Refer to MOST (Online Platform for YPs)? If YP is under 15 we need parental consent** Yes [ ]  No [ ]

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

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

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

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

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

**Address:­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suburb: \_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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:**  **Y**es [ ]  No [ ]  **Home Phone:** Yes [ ]  No [ ]

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

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

(If under the age of 16 years parent/guardian consent may be required)

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

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

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_ Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicare #:** \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ Reference No: \_\_\_\_\_\_\_ Expiry Date: \_\_\_\_ / \_\_\_\_\_\_\_\_ [ ]  On file

**Health Care Card #:** \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ Expiry Date: \_\_\_\_ / \_\_\_\_\_\_\_\_ [ ]  on file

**Do you feel in crisis or at risk of harm to yourself or others?** \_\_\_\_\_\_\_\_\_ **(If yes, transfer to intake)**

**Details of Referrer**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Agency:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Contact Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does the Young Person have a GP?** Yes [ ]  No [ ]  **If no,** Local GP information provided[ ]

**Can we contact them? Yes** [ ]  No [ ]

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Medical Centre:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current MHCP?** Yes [ ]  No [ ]  Date completed by GP: **\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_**

**Documents attached:** Referral Letter [ ]  Discharge Summary [ ]  Mental Health Care Plan [ ]  Notes [ ]