**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

**PREFERENCE OF COUNSELLOR: M**   **F**

**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

|  |  |  |  |
| --- | --- | --- | --- |
| **Official Document Control** | | | |
| **Version Number** | **Purpose/change** | **Approver** | **Date** |
| 2 | Revision | Executive Manager | 02/04/2024 |