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| **Referrer Details** |
| **Name** |  | **Referral Date** |  |
| **Service** |  |
| **Contact Number** |  | **Contact Email** |  |

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| **Young Person’s Details** |
| **Name** |  |
| **Date of Birth** |  |
| **Gender** | *(male / female / non binary / transgender / prefer not to say)* |
| **Preferred Pronouns** |  |
| *Completion of referral indicates consent for headspace to contact referrer and young person* |
| **Contact Number** | Mobile: Consent from young person to send SMS Y / N Voicemail Y / N |
| **Next of Kin** | Name:Contact Number:Consent to liaise with NOK: Y / N |
| **Parent/Guardian Consent for young people under 16 years** | Name / Contact Details (*if different to above):*Y / N |

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| **Reason for Referral** |
| Mental Health | Education Barriers | Conduct Difficulties | Sexuality / Gender |
| Drug and Alcohol | Employment | Police Involvement | Trauma |
| Physical Health | Risk of Homelessness | Family Conflict | Relationship Concerns |

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| **Additional Referral Information** |
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| **Risk**  |
| Is the young person currently suicidal? | **Y / N***If Yes, please refer to Child and Youth Mental Health or Adult Mental Health and/or phone headspace to discuss referral* |
| Are there additional risk areas identified for the young person? | **Y / N**If Yes, provide additional detail: |
| Additional Referral/s Made |  |

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