# Referral Form

## headspace Hervey Bay and Maryborough

**Important information regarding your referral, please read:**

- **If the young person is experiencing high levels of distress which may result in harm to themselves or others, or is at high or acute risk of suicide, they are not suitable for headspace services.** Please contact 1300 MH CALL on 1300 642 255 (24 hours) to speak to an Acute Care Clinician, refer them directly to the Emergency Department of the nearest hospital, or contact emergency services on 000.
- headspace is an **early intervention and prevention service**. We offer **short-term brief intervention** to young people between the ages of 12 to 25 who are **experiencing mild to moderate** mental health issues. We typically provide **6 to 10 therapy sessions**, depending on a young person's need.
- Please note we are a **voluntary** service, and we can only engage with young people who have **provided consent** to the referral.
- It is a requirement that at **minimum 24 hours** notice is given to canceling or rescheduling appointments.
- Please note that receipt of the referral does not indicate acceptance to the headspace services. We may complete an intake appointment and assessment with the young person to determine their most suitable care options. headspace may support the young person by referring them to other services when deemed appropriate.
- Our centre collaborates with other Wesley Mission headspace centres. Those centres may have additional capacity to support our young people via telehealth or video appointments where applicable.
- Please provide and attach as much information as possible as it ensures the best quality of care, best outcome and if required appropriate external referral.
- After we have received this referral, you will be contacted within 5 business days to arrange an initial triage appointment.
- This triage appointment will be arranged within 3 weeks of initial contact.
- If no contact is made in this period please call the centre on 07 4303 2100.

***Please sign that you have read the information above***: _____ ***Date***: _____

# Referral Form

## headspace Hervey Bay and Maryborough

| | | | | | |
|---|---|---|---|---|---|
| Referral Date: | | Referral Source: | | What school do you attend? (If applicable) | |
| Is the young person aware of this referral and willing to engage in services? ☐ Yes ☐ No | | | Do you consent to your de-identified data being shared with headspace funders? ☐ Yes ☐ No | | |

| **Client Details** | | | | | |
|---|---|---|---|---|---|
| First Name: | | Last Name: | | Preferred Name: | |
| Date of Birth: | | | Medicare Number: | Exp | |
| Contact Number: | | | Email Address: | | |
| Address & Suburb: | | | | Post Code: | |
| Gender Identity: | ☐ Male ☐ Female ☐ Questioning ☐ Other: _____ | | | Title & Pronouns: | |
| Sexual Orientation: | ☐ Straight ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Questioning ☐ Other Sexuality: _____ | | | | |

| **Client Identity** | |
|---|---|
| Do you identify as Aboriginal or Torres Strait Islander? | Do you speak a language other than English at home? |
| ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ N/A<br>Who is your mob? _____ | ☐ Yes (Please State): _____<br>☐ No |
| What is your country of birth? _____ | Accessibility Requirements? _____ |

| **External Service Involvement (i.e. Child Safety, Youth Justice, etc.)** | | | |
|---|---|---|---|
| Service Name: | | Contact Person: | |
| Service Name: | | Contact Person: | |
| Is the young person linked in with child safety? ☐ Yes ☐ No | | Child Safety Contact: | |
| We offer telehealth appointments at our centre, do you consent to a telehealth appointment if it comes available? ☐ Yes ☐ No | | | |

| **Emergency Contact Details** | | | |
|---|---|---|---|
| Primary Contact Name: | | Secondary Contact Name: | |
| Phone Number: | | Phone Number: | |
| Relationship: | | Relationship: | |
| Can we contact this person about appointments? ☐ Yes ☐ No | | Can we contact this person about appointments? ☐ Yes ☐ No | |
| Would this person like to join our Friends and Family Committee or know more about it? ☐ Yes ☐ No | | Would this person like to join our Friends and Family Committee or know more about it? ☐ Yes ☐ No | |

| | |
|---|---|
| ☐ Are you currently or wanting to study or look for employment? | Would you like to be linked in with our headspace Work and Study team to help you with this? ☐ Yes ☐ No |

| **Reason for referral and any additional information (i.e. mental health support, sexual health support, addiction support)** |
|---|
| *How did you hear about us?*_____ |

**Please email referral forms to the below email addresses:**

**Hervey Bay**: faxherveybayheadspace@wmq.org.au **Maryborough**: fax.maryborough.headspace@wmq.org.au

***Please also attach any additional information from GP, Youth Justice, Child safety, etc. e.g. Mental Health Care Plan.***