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| **What does headspace do?** headspace Midland is a *Youth Mental Health service for young people aged 12-25* experiencing mild to moderate mental health difficulties (also known as a Tier 2 service). We offer a range of support options and can also help connect young people with other community services. Our service is primarily focused on short-term support; if longer-term care is required, we can provide recommendations or referrals to more appropriate services.**What happens after a referral is submitted?**After a referral is submitted, an intake officer will aim to make contact within 5 business days to complete an intake call. If another service would be a better fit, headspace Midland will notify the referring agency of these recommendations. If we are unable to reach the young person—or their parent/carer for those under the age of 16—we will notify the referring agency. |
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| **Prior to Completing the Referral** |
| ***Please tick to acknowledge that you have read the following points prior to completing the referral.***[ ]  Young person is aware and consenting to the referral.[ ]  Young person is experiencing mild to moderate mental health difficulties. [ ]  We are a multidisciplinary team and do not accommodate discipline specific requests (e.g., requests for clinical psychologist). [ ]  We do **not** provide psychiatry. *Psychiatry and individual outreach are available through our headspace Early Psychosis Service,* [*click here for more information*](https://headspace.org.au/headspace-centres/midland/) *or contact them at 9301 8999.*[ ]  **We are not a crisis service**. We aim to attempt to contact the young person within 5 business days of receiving a referral. If an appointment is offered, we endeavour for the young person to be seen within 2-4 weeks. *(Please note wait times vary and are subject to service demand).****If you are unsure if headspace is the best support option for a particular young person, please contact our triage officer on 9274 8860 to discuss support options.*** |
| **Young Person’s Details**  | **Referral Date:** Click or tap to enter a date. |
| **Full Name:** | Click or tap here to enter text. | **Date of Birth:** | Click or tap to enter a date. |
| **Preferred Name:** | Click or tap here to enter text. | **Pronouns:** | Click or tap here to enter text. |
| ***Is the preferred name and pronouns known to the wider community/family/friends?***[ ]  **Yes** [ ]  **No** [ ]  **Unknown** |
| **Sex:** | Click or tap here to enter text. | **Gender:** | Click or tap here to enter text. |
| **Phone:** | Click or tap here to enter text. | **Email:** | Click or tap here to enter text. |
| **Address:** | Click or tap here to enter text. |
| **Medicare:** | Card Number: | Click or tap here to enter text. | Index:  |       | Expiry:       | /       |
| **Does young person identify within the LGBTQIA+ community** (Lesbian / Gay / Bisexual / Transgender / Queer or Questioning / Intersex / Asexual/ Other)**?** [ ]  No [ ]  Yes [ ]  Unknown       |
| **Cultural Identity:** |  [ ]  Aboriginal [ ]  Torres Strait Islander [ ]  Both [ ]  Neither |
| [ ]  Another Culture: Click or tap here to enter text. |
| **Young Person’s Consent** |
| **Is the young person aware and consenting to this referral being made?***(headspace requires the young person’s consent, the referral will not proceed without consent)* | [ ]  Yes [ ]  No |
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| **Emergency Contact / Next of Kin / Guardian Details** |

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| --- | --- | --- | --- |
| **Full Name:** | Click or tap here to enter text. | **Relationship:** | Click or tap here to enter text. |
| **Phone Number:** | Click or tap here to enter text. | **Email:** | Click or tap here to enter text. |
|  |  |
| **Please confirm the emergency contact/next of kin is over the age of 18.** *(headspace requires an emergency contact to be 18 years old or older.)* | [ ]  Yes |
| **Does the young person live with this person?** | [ ]  Yes [ ]  No |
| **Can this person schedule/cancel appointments?**  | [ ]  Yes [ ]  No |
| **Is this person aware that the young person is accessing headspace Midland?** *(If the young person is under the age of 16, parent/guardian consent may be required)* | [ ]  Yes [ ]  No |

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| **Referrer Details** |
| **Referral Source:** | [ ]  Young Person [ ]  Family / Friend [ ]  Agency [ ]  GP [ ]  Other  |
| **Name:** | Click or tap here to enter text. | **Phone Number:** | Click or tap here to enter text. |
| **Organisation:** | Click or tap here to enter text. | **Email:** | Click or tap here to enter text. |
| **Is young person currently admitted to hospital?** | [ ]  Yes [ ]  No |
| If *yes*, when is their estimated discharge date? Please consider phoning triage to discuss suitability of referral prior to completing. EDD: Click or tap to enter a date. |
| **Is young person receiving support from another mental health service?**  | [ ]  Yes [ ]  No |
| *Name of Service:* | Click or tap here to enter text. |
| **Have you referred young person to any other service?** | [ ]  Yes [ ]  No |
| *Name of Service:* | Click or tap here to enter text. |

*\*Please note psychiatry at headspace Midland is only available for young people accessing the headspace Early Psychosis Service.* [*Click here for more information*](https://headspace.org.au/headspace-centres/midland/)*.*

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| **Presenting Concerns** |
| [ ]  Mental health | [ ]  Situational | [ ]  Social support |
| [ ]  Physical health | [ ]  Home or environment | [ ]  Friendships |
| [ ]  Sexual health | [ ]  Family support | [ ]  Relationships / Sexuality |
| [ ]  Alcohol and drugs | [ ]  Eating and body image | [ ]  Vocational / Educational |
| **Please elaborate (include duration):** Click or tap here to enter text. |
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| **Relevant Background Information** |
|  |
| **Previous mental health diagnosis/treatments and other relevant background information:**(Diagnosing or treating practitioner, dates, interventions, medications, etc)Click or tap here to enter text. |
|  |
| **Other relevant information:** (Physical health concerns, developmental or learning disabilities, family history, etc)Click or tap here to enter text. |
|  |
| **Additional support requirements:** (Translator, interpreter, wheelchair-accessible room, etc.)Click or tap here to enter text. |
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| **Supporting Documentation** |

**Please forward any available relevant documentation** reception@headspacemidland.com.au

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| **Attached:** | [ ]  Referral Letter [ ]  Discharge Summary [ ]  Mental Health Care Plan [ ]  Other |

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| **Risk Concerns** |

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| **Risk** | **Current**(within past month) | **Recent**(within 6 months) | **Historical**(6 months +) | **No** | **Unknown** |
| Non-suicidal self-injury |[ ] [ ] [ ] [ ] [ ]
| Suicide ideation |[ ] [ ] [ ] [ ] [ ]
| Suicide attempt |[ ] [ ] [ ] [ ] [ ]
| Substance use |[ ] [ ] [ ] [ ] [ ]
| Risk of harm *to* others |[ ] [ ] [ ] [ ] [ ]
| Risk of harm *from* others |[ ] [ ] [ ] [ ] [ ]
| Homelessness |[ ] [ ] [ ] [ ] [ ]
| Psychosis/mania |[ ] [ ] [ ] [ ] [ ]

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| **Please provide more information if risk concerns are current:** Click or tap here to enter text. |

**Once completed, please forward this form and all supporting documentation to headspace Midland via fax (08) 9274 8859 or email** **reception@headspacemidland.com.au****.**

Please note that **headspace** **Midland** does not provide crisis or acute care mental health services.

For mental health emergencies contact the Mental Health Emergency Response Line (18+): 1300 555 788 or CAMHS Crisis Connect (under 18): 1800 048 636.

We are unable to provide psychological assessments or reports for another purpose (e.g., in relation to Workers Compensation, Centrelink or Court matters). For further information, please contact **headspace** **Midland** by calling (08) 9274 8860 or emailing reception@headspacemidland.com.au.