**Young Person (Client) Details Date: **

Name: …………………..……………….. DOB: .…./.…./.…. Sex: M / F / Other ………

Address: ………………….………………………………………………………………......

Phone: ……………………………. Mobile: …………………………….………..…

Who do we contact for appointments? …………………………………………………….

Lives with: ……………………… NOK / Other contact person: …………….………….

NOK Relationship: ………..…… NOK Ph: ….…….… NOK Mob: ….….……….……..

Educational Status (highest level obtained): ………………………………………………

School/Institution: …………………………………………………………………………….

Usual Occupation: ……………………. Employment Status: ………………..………..

If no longer at school/work, how long has this been the case? ………………....………

Is the person on any Centrelink payments (if so please list): ……………………………

Country of Birth: …………………. Cultural/Indigenous Identity: ………………….……

Pref. Language: ………………….. Language Spoken at Home: ………………….……

**Referrer Details**

Name: ……………………………... Job Title: ……………………..……………….

Organisation/Service: ……………………….. Ph: ………………. Fax: ………….……..

Is the client aware of and has consented to the referral and wanting treatment?

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Does the client have their own GP? ………………………………………………………..

GP Details (name, practice, address) ………………………………………………..…….

If yes, has a Mental Health Treatment Plan been created? Yes / No / Unsure

Presenting Problem (What are your main concerns regarding this young person? Including mental and physical health concerns, drug/alcohol use and vocational issues):

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What does the young person see as the problem?

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Duration of current problem ………………………………………………………..………………………………..………

Relevant background information

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Previous mental health diagnosis / Treatment (By whom / dates / medications / include any developmental disabilities):

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Other services involved (Previous / Current)

Risk (please tick if a current concern, and provide additional details)

Suicide / Self harm Harm to others Homelessness Substance use / Abuse

Extreme social withdrawal School avoidance / absenteeism Psychosis / Mania

Other, please provide details: .......................................................................................................................................

What assistance would you like from headspace Midland?

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Please attach more detail to this assessment if necessary.
The completed referral form can be faxed or emailed.
Please note that headspace Midland does not provide crisis or acute care mental health services.
For mental health emergencies contact: Mental Health Emergency Response Line on 1300 555 788.