PROFESSIONAL REFERRAL FORM

Please return completed referral form to headspace Mildura via:
F: **03 5023 6760**
E: referrals@headspacemildura.com.au

*If no acknowledgment receipt is received, please contact Centre Administration to confirm receipt on **03 5021 2400***

Referral criteria: young person must be aged between 12-25 years and must give consent for the referral.

Has consent been obtained? Yes ☐ **No** ☐ ***if no, please do not proceed; headspace Mildura cannot respond to the referral or contact the young person without their consent***

Services provided will be inclusive of, and not limited to, early intervention for:

- Mental & physical health concerns
- Use of alcohol and other substances
- Vocation and Education support

Please note: headspace Mildura is not an acute mental health/crisis service. If you have concerns for the young person's immediate safety, please contact Mildura Base Public Hospital - Mental Health Services Triage on 5022 3500. For urgent medical assistance, please call 000.

REFERRER DETAILS

Name:	
Organisation:	
Position:	
Phone number:	
Email:	

YOUNG PERSON DETAILS

Full name:	
Preferred name:	
Date of Birth:	**Age:**
Gender:	
Pronouns:	----------
Address:	
Phone:	
Email:	

Is the young person of Aboriginal or Torres Islander Origin? Aboriginal ☐ Torres Strait Islander ☐

What is the young person's main cultural background other than Australian or Aboriginal and Torres Strait Islander?

Is an interpreter required? No ☐ Yes ☐ language required

EMERGENCY CONTACT DETAILS (Must be over 18)

Full name:	
Relationship:	
Phone/Email:	
Address:	

Is the listed emergency contact aware of this referral? Yes ☐ No ☐

Who should headspace Mildura first contact to discuss the referral further?

Young Person ☐ Emergency contact ☐ Referrer ☐ Other ☐

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SERVICE ENGAGEMENT
(Please attach applicable documents)

GP Details:

Other organisations/services/ supports (please provide details)**:**

School based support (e.g. SSSO, IEP/ILP, student wellbeing)**:**

Mental Health Treatment Plan: Yes ☐ No ☐
NDIS Plan: Yes ☐ No ☐
Allergies: Yes ☐ No ☐
Medical history/Medications (if known):

GOVERNMENT CARDS

Medicare (required for physical/sexual health clinic)	Card number	
	Reference	
	Expiry date	
Centrelink (e.g. health care/pensioner)	Reference	
	Expiry date	

REASON FOR REFERRAL
Please list reasons for referral and relevant history*

Has the Young Person expressed thoughts of self harm or suicide? No ☐ Yes - self harm ☐ Yes - suicide ☐
Is the Young Person engaging in self harming behaviour? No ☐ Yes ☐ Unknown ☐
Is the Young Person currently at risk of suicide? No ☐ Yes ☐ Unknown ☐

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Will you be continuing to support the Young Person after their referral to headspace Mildura? Yes ☐ No ☐

**This referral is to be discussed with the young person and consent must be obtained prior to submission.*
A team member will be in touch with the nominated contact within the next 3 business days. Thank you for your referral.

Young person's signature: ..... **Date**: .....
Young Person's verbal consent obtained: ☐ **Date:** .....
Referrer signature: ..... **Date**: .....

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headspace National Youth Mental Health Foundation is funded by the Australian Government Department of Health
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