REFERRAL FORM

Referrer to complete form, fax to **headspace** Mildura (fax: 5023 6760) or e-mail to referrals@headspacemildura.com.au and follow up with phone call (5021 2400) to ensure receipt of referral.

Referral criteria: 12-25 years old, early intervention. headspace Mildura often supports clients by referring them to other services where appropriate.

Please note headspace Mildura is not an acute mental health/crisis service. If the matter is urgent please contact Mildura Mental Health Service Triage on 5022 3500.

REFERRER'S DETAILS

Agency/Position:	
Name:	
Contact details (inc. e-mail):	

CLIENT INFORMATION

Surname:		Given names:			
Preferred name:		Date of birth:		Age:	
Gender:					
Address:					
Phone:		Email:			
Does the young person identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Other					
Preferred language:		Interpreter required: ☐ Yes ☐ No			
Emergency contact name:			Relationship:		
Address:			Phone:		

Is the client linked with other services? Yes ☐ No ☐ If "Yes" please provide details (including GP):

REASON FOR REFERRAL

What is the reason for referral and any relevant history?

If the referral concerns school issues, have school support staff been involved? What steps have been taken (e.g. SSSO, ISP, student wellbeing, parent engagement)?

CLIENT GOALS

Please list the goals the client wishes to work on.

CLIENT CONSENT

This referral must be discussed with the client. **headspace** Mildura is unable to contact the client without their consent.

Do you have the client's consent for this referral? ☐ Yes ☐ No
(Where possible, please have the client sign below)

Are the parents/carers aware of this referral? ☐ Yes ☐ No

If 'No', what is the plan for transport?

Client signature: _____ Date: _____