Client Referral Form for Professionals

Referral Date: ____/____/_____

Email	Healthlink EDI	Fax	Phone
barker@ireach.org.au	ireachhm	(08) 8398 4269	(08) 8398 4262

Referral Guidelines

headspace Mount Barker is funded by Country PHN, and administered by iREACH Rural Health, to provide a range of free, youth-friendly and confidential services for young people aged **12- 25 years**, within the Adelaide Hills region. **headspace** Mount Barker aims to be a one-stop-shop for young people with mild -moderate physical, psychological or social difficulties, and young people with complex care needs not meeting the criteria for Tertiary Government Mental Health Services, i.e.- not high risk, but needing support in multiple domains.

The services available at headspace Mount Barker include:

- Individual Mental Health Support.
- Psychosocial Support – group activity, Youth Reference Group.
- Therapeutic Group Mental Health Support.
- Tele-psychiatry appointments – for current headspace clients only.
- GP appointments – for mental health, physical and/or sexual health issues.

Please note – we are unable to provide medico-legal reports but may be able to provide a note of attendance.

Important Information – Please read

Important information regarding your referral:
For us to process this referral promptly, please ensure that you have included all relevant information in legible print.

- **headspace** is a service for young people between the ages of 12 to 25. We can only engage with young people who have provided consent to the referral.
- **headspace** is not a crisis/ acute mental health service. If the young person is at high or acute risk of suicide or harm to others, please contact emergency services on 000 or Mental Health Triage on 13 14 65.
- **Please note that receipt of the referral form does *not* indicate acceptance to the headspace services**. All referrals are triaged to determine the pathway that best meets the young person's needs. The referrer may be contacted if more information is required and may mean the referral is forwarded to an external service to meet the young person's needs. If you have any queries pertaining to your referral, please phone our service.
- **Waitlist**- given the demand for **headspace** services, there may be a waitlist at times. We request that you seek urgent help from your GP or local hospital should your situation change. We can recommend a list of services that young people can access while on the waitlist, including **eheadspace** and Beyond Blue.

Young Person's Details ***PLEASE PRINT CLEARLY***

Legal First Name: _____ **Preferred Name:** _____

Surname:_____ **Previous client:** Yes ☐ No ☐ Unknown ☐

Date of Birth: _____ **Age:** _____

Gender: _____ **Preferred Pronouns:** _____

Young Person's Postal Address: _____

Is it ok for us to send headspace branded letters/documents to this address? Yes ☐ No ☐

Young Person's Phone Number: _____ **Email:** _____

Country of Birth _____ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Prefer not to say ☐

NDIS Status: Funded ☐ Applying ☐ N/A ☐ **Is the Young Person involved in legal matters:** Yes ☐ No ☐

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Referral Date: ____/____/_____

Referrer's Details

Referrer Full Name: _____

Contact Number: _____ **Email:** _____

Workplace: _____

Young Person's Key Contact Person *(in case of emergency)*

Name: _____ **Relationship to Young Person:** _____

Contact Number(s): _____

Address: _____

Reason for Referral *(what is the main problem the young person is seeking help with?)*

Health Professionals - *please attach a current Risk Assessment, Mental State Examination, Summary of Care Episode and service requested.*

Educational and Housing services *– please include a safety assessment and current Summary of Care.*

_____

_____

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_____

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Other Information

Has the Young Person been asked to attend a GP to obtain a Mental Health Care Plan? Yes ☐ No ☐

Does the Young Person have an existing GP? Yes ☐ No ☐

GPs Name:_____

Practice Name: _____**Phone:** _____

Medicare Number: _____**Ref/position:**_____ **Expiry:**_____

Consent

Young Person is aware of the referral, has given consent and wants to attend headspace: Yes ☐ No ☐

******PRIVACY******

If the Young Person does not want their parents or carers to know about them accessing our services, please let us know and we will note this on their file. **Doesn't Mind ☐** **Keep Private ☐**

Young People under the age of 16 years need to have a responsible adult's consent to access our services