Service Provider Referral form

Referral to headspace services
(please select one and forward to nearest centre)

☐ Mt Druitt	☐ Parramatta (for headspace Early Psychosis program referrals only, for Primary Care referrals please click here)	☐ Penrith
Shop 12, Daniel Thomas Plaza, 6-10 Mount St, Mt Druitt, NSW 2770 ***Phone:*** *(02) 8881 2500* ***Fax:*** *(02) 4720 8899* ***Email:*** *headspacemtdruitt@parramattamission.org.au*	2 Wentworth St, Parramatta, NSW, 2150 ***Phone:*** *1300 737 616* ***Fax:*** *(02) 8331 6056* ***Email:*** *headspaceparramatta@parramattamission.org.au*	606 High St, Penrith, NSW, 2750 ***Phone:*** *(02) 4720 8800* ***Fax:*** *(02) 4720 8844* ***Email:*** *headspacepenrith@parramattamission.org.au*

Important information regarding your referral, please read:

- **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. *N.B. If the young person is unable to provide informed consent due to mental state (e.g. psychosis), please contact us.*
- If the young person is at high or acute risk of suicide, please contact emergency services on 000.
- Please note that receipt of the referral form does not indicate acceptance to the **headspace** services. Suitability of the referral will be determined following assessment with the young person. Please contact the relevant **headspace** site to confirm receipt and discuss the outcome of your referral.
- To assist with the referral, please attach any relevant assessment notes, discharge summaries and/or additional information. We will endeavour to respond to referrals within 24 – 48 hours business hours. If you have any queries pertaining to your referral, please call the relevant site using the contact details above.

Consent for referral: *If the young person is unable to provide informed consent due to mental state (e.g. psychosis), please contact us.*

Has the young person consented to and provided permission to exchange information in relation to this referral?	☐ **Yes**	☐ **No**

Primary reason(s) for referral: This section must be completed. Please contact us for queries regarding services available.

☐	Short-term Mental Health Intervention with **headspace** Primary Care Team Does the YP have a Mental Health Care Plan? ☐ Yes ☐ No		
☐	Assessment with **headspace** Early Psychosis Program		
☐	Drug and Alcohol Support	☐	Vocational Support
☐	Physical Health Support		

Referrer details: We will be corresponding with you using the below details. Please ensure that all details listed below are current.

Name of Referrer:		Organisation:	
Relationship to Young Person:		Designation:	
Contact Number:		Fax:	
Service Address:			
Email:			

Parent/guardian details: * please note that if the Young person is aged 15 and under, we will require a parent or guardian to be documented on this form.

Name:			
Relationship to young person:		Contact Number:	
Do we have permission to speak with the young person identified?	☐ Yes	☐ No	

Young Person's details:

Name:					
Date of Birth:		Age:		Gender:	
Address:					
Suburb:				Postcode:	
Contact Number 1:		2.			
Medicare Card Details:			Expiry Date:		
Interpreter Required?	☐ Yes, Language:		☐ No		
Assistance with Reading/Writing?	☐ Yes		☐ No		

Presenting Issues:

Current presenting issues (please include duration, age of onset, and any relevant pre-existing diagnoses):

Impact of problem on functioning: (e.g. relationships/school/home/work)

Please indicate if there is any known family history of mental health conditions:

Previous/current engagement with headspace or other services:

Risk Factors:

☐ Suicide ☐ Non-accidental self-injury ☐ Harm to others ☐ Extreme social withdrawal

☐ Homelessness ☐ Substance use ☐ Accidental Death ☐ Non-compliance

Details:

Referrer's Signature:

By signing this document, the referrer agrees that the above information is accurate and current to their knowledge

Date:

Office Use Only

Plan (to be reviewed at intake meeting): ***When booking appointment, please request that the young person attends 15 minutes prior to their appointment time***

□ Book with YAT Clinician	Date/Time: _____	Clinician: _____
□ Joint YAT/MATT Consultation	Date/Time: _____	Clinician: _____
□ Direct Allocation to CCT	Date/Time: _____	Clinician: _____
□ MATT Assessment		
□ Referral to Co-located LHD Team	Date/Time: _____	Clinician(s): _____
□ Declined/Referred Elsewhere	Recommendations Made: _____	

If you need to speak to someone urgently, please call Lifeline on 13 11 14, Kids helpline 1800 55 1800 or the NSW Mental Health Line 1800 011 511.

If you need immediate support, call 000.

You can also get help in person at a headspace centre located near you or via our online support service at eheadspace. Visit:

headspace.org.au/headspace-centres/
headspace.org.au/eheadspace/.

headspace Mount Druitt

headspace Penrith

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