|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Young Person’s Details:** | | | | | | | | | | | | | |
| **Name:** | | | | | **DOB:** | | | | | **Age:** | | | |
| **Preferred Name (and pronouns):** | | | | | | | **Gender:** | | | | | | |
| **Address:** | | | | | | | | | | | | | |
| **Postal Address:** | | | | | **Town/Suburb:** | | | | | | | | |
| **E-mail:** | | | | | **Phone:** | | | | | | | | |
| **Is the young person under 16?** | | | | | | | | | | Yes | | No | |
| **If under 16, is the parent/caregiver aware of the referral?** | | | | | | | | | | Yes | | No | |
| **Country of birth:** | | | | **Emergency Contact name:** | | | | | | | | | |
| **Phone:** | | | | **Relationship to young person:** | | | | | | | | | |
| **Referrer Information: (Tick if details are the same as emergency contact)** | | | | | | | | | | | | | |
| **Name:** | | | | **Phone Number:** | | | | | | | | | |
| **Role & Organisation:** | | | | **Relationship to young person:** | | | | | | | | | |
| **E-mail:** | | | | | | | | | | | | | |
| **Appointments: (Tick all that apply)** | | | | | | | | | | | | | |
| **Preferred appointment method:** | | In person | | | Phone | | | | Digital | | | | |
| **Who should be contacted to make appointments?** | | Young person | | | Referrer | | | | Emergency Contact | | | | |
| *Only complete this section below if you would like to access physical health services at headspace* | | | | | | | | | | | | | |
| **GP/Medical clinic:** | | | | | | | | | | | | | |
| **Medicare number:** | | | | | | **Ref:** | | **Expiry:** \_\_\_\_\_\_/\_\_\_\_\_\_ | | | | | |
| **Health Care Card:** | Yes No | | **CRN:** | | | | | **Expiry:** \_\_\_\_\_\_/\_\_\_\_\_\_ | | | | | |
| **Does the young person have a Mental Health Treatment Plan?** | | | | | | | | | | | Yes | | No |

|  |
| --- |
| **Reasons for Referral:** |

**What are the main reasons for this referral?**

**How is this impacting your/the young person’s daily life and how long for?**

**Have you/the young person accessed any mental health services before? (Please include any formal diagnosis).**

|  |
| --- |
| **Risk Factors:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Suicide** | No | Thoughts | Plan | Intent |
| ***Details:*** | | | | |
| **Self-Harm** | No | Past | Current | Unknown |
| ***Details:*** | | | | |
| **Harm to others** | No | Yes | Unknown | |
| ***Details:*** | | | | |
| **Other risk factors** (e.g. homelessness, substance abuse, social withdrawal, medication compliance) | | | | |
| ***Details:*** | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Consent:** | | | | | | |
| *If the young person is under 16 years of age, a parent/guardian must provide consent.* | | | | | | |
| Do you consent for headspace to add the young person to our database? | | | | | Yes | No |
| Do you consent to receive your pre-appointment survey via text message? | | | | | Yes | No |
| **Consent type:** | Verbal | Written | **Name of person consenting:** | | | |
| **Young person signature:** | | | | **Date:** | | |
| **Parent/Guardian signature:** | | | | **Date:** | | |
| **Referrer signature:** | | | | **Date:** | | |