# A green and black design Description automatically generatedHEADSPACE MOUNT ISA COMMUNITY REFERRAL FORM

# Referral criteria: 12 -25 years old for early intervention service.

# This is not an acute service

*IF YOU NEED IMMEDIATE ASSISTANCE OR THIS IS AN EMERGENCY, PLEASE CALL 000 OR PRESENT TO EMERGENCY DEPARTMENT AT THE HOSPITAL.*

### Please complete as much information as possible in this form. Let us know if you need assistance with completing this form.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of Referral:** | | Click or tap to enter a date. | | |
| **Have you been here before?** | | **Yes No Unsure** | | |
| **Referral Source:** | | **Self/Walk-in**  **GP**  **Government**  **Service** | **Friend**  **School**  **Community**  **Service** | **Family**  **Allied Health**  **Professional**  **Other** |
| **Please specify:**Click or tap here to enter text. | | |
| **Client Details Below:** | | | | |
| **Full Name:** | Click or tap here to enter text. | | | |
| **Date Of Birth:** | Click or tap to enter a date. | | | |
| **Gender:** | **Male Female Intersex Transgender**  **Other:**Click or tap here to enter text. | | | |
| **Ethnicity:** | **Aboriginal Torres Strait Islander Australian Caucasian**  **Other:**Click or tap here to enter text. | | | |
| **Address:** | Click or tap here to enter text. | | | |
| **Phone:** | Click or tap here to enter text. | | | |
| **Mobile:** | Click or tap here to enter text. | | | |
| **Email address:** | Click or tap here to enter text. | | | |
| **Do you consent to receive SMS messages for appointment reminders; clinical reminders, centre promotions, etc.? Yes No** | | | | |

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| --- | --- | --- | --- | --- |
| **Referral Details Below (If referring yourself – skip this part)** | | | | |
| **Full Name:** | | Click or tap here to enter text. | | |
| **Relationship to Client:** | | Click or tap here to enter text. | | |
| **Address:** | | Click or tap here to enter text. | | |
| **Phone No:** | | Click or tap here to enter text. | | |
| **Mobile No:** | | Click or tap here to enter text. | | |
| **Email Address:** | | Click or tap here to enter text. | | |
| **Medicare Card No:** | Click or tap here to enter text. | | | |
| **Reference No:**Click or tap here to enter text. | | | **Expiry Date:**Click or tap to enter a date. |
| **Healthcare Card No: (if any)** | Click or tap here to enter text. | | | **Expiry Date:**Click or tap to enter a date. |
| **Reason/s for Referral:(please explain):**  **Mental Health (talk to someone):**  Click or tap here to enter text.  **Sexual Health (STI and Birth control/planning):**  Click or tap here to enter text.  **Work & Study (15-25YO):**  Click or tap here to enter text.  **Drugs and Alcohol:**  Click or tap here to enter text.  **Psychiatrist:**  Click or tap here to enter text.  **What are the presenting concerns or issues?**  Click or tap here to enter text.  Do you have any goals you’d like to work on with headspace?  Click or tap here to enter text. | | | | |
| **Is client linked with other services?** | | | | |
| **Yes No** | | | | |
| **If “Yes”, please list them:** | | | Click or tap here to enter text. | |

|  |  |
| --- | --- |
| **Emergency Contact Details Below (If same as Referrer – skip this part)** | |
| **Full Name:** | Click or tap here to enter text. |
| **Relationship to Client:** | Click or tap here to enter text. |
| **Address:** | Click or tap here to enter text. |
| **Phone No:** | Click or tap here to enter text. |
| **Mobile No:** | Click or tap here to enter text. |
| **Email Address:** | Click or tap here to enter text. |
| **How did you find out about this services?**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Family/Friends** | **Internet/Online** | | **Community Service** | **Radio** | | **Health Professional** | **Newspaper** | | **Presentations/Workshop** | **GP** | | **TV** | **Walked Past** | | **Pamphlets** | **Psychiatrist** | | **An Event:** | **Other** | Click or tap here to enter text. | | | | |
| **Client Consent:** | |
| ***This referral must be discussed with the client.***  ***Please note - headspace Mount Isa is unable to contact them without their consent.*** | |
| **Do you have the client's consent (permission) for this referral?**  **Yes No (If "Yes", please have client sign here) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **If under 14 years of age, parents/guardian is to sign below**  **Parent/Carer signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Referrer's signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_** | |

Please send referral through to [reception@headspacemtisa.org.au](mailto:reception@headspacemtisa.org.au)