# 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. |

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| **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. |

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| **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