

### Important information for your referral, Please Read

- headspace is a service for young people between the ages of 12 to 25 years.
- We can only engage with young people who have provided consent to the referral. 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 headspace Newcastle to confirm receipt and discuss the outcome of your referral.
- **To complete the referral, you must attach relevant assessment notes, discharge summaries and/or additional information**

### Consent to Referral

- Has the young person given consent for the referral?  Yes  No
- Has the young person's (if under 16) parents/caregivers consented to the referral?  Yes  No
- Does the young person have a Mental Health Care Plan (MHCP)?  Yes  No

**If no, please encourage young person to obtain a MHCP as this will assist to speed up the allocation process**

Has the young person given consent to provide their email address to receive updates about their headspace referral and upcoming programs:

No  Yes, please provide email:

### Young Person's Details

Name:  Contact number:

Date of Birth:  Age:

Medicare Card No.:  Expiry:  Healthcare card:

Address:

Suburb:  Post code:

Gender:  Pronouns:

### Does the young person identify as (optional):

- Aboriginal  Torres Strait Islander  Aboriginal & Torres Strait Islander  LGBTQIA+:
- Culturally & Linguistically Diverse (CALD)  Not known  Others, please specify:

### Does the young person have any difficulties with literacy:

No  Yes, please explain:

### Referral Method

- Referral (Family/Friend)  Self referral  GP  Other Service:

**Next of Kin - Note: NOK must be over 18yo**

Name:  Relationship to YP   
Address:  Contact Number:

**Referrer Details - Note: not needed if self-referring**

Name of Referrer:  Organisation:   
Relationship to YP:  Contact Number:   
Address:   
Email:

**Required Services - Please indicate which services would be beneficial**

Mental Health Support    Physical health (GP) Support    Drug & Alcohol Support    Work & Study Support

**Presenting Issues**

Anger    Anxiety    Bullying    Depression    Relationships  
 Self-Harm    Stress    Substance Use    Suicidal Ideation    Trauma  
 Other (E.g. Legal Issues)   Details:

**Referral Information (please complete this section):**

Please attach any extra relevant information and assessments e.g. summary, assessment information

**Tertiary Mental Health Services:** Please attach Risk Assessment, A1, Discharge Summary

**\*\*Please note we may be unable to process/accept referral if this information is not received**

Please include: Risk information, Legal information, current presenting issues, impact of problem on functioning and if family history of mental health conditions.

*(The above field has an 880 character limit. Please attach additional documentation should you require more space)*

Thanks for making a referral to headspace Newcastle. You can return the referral form by:

**Fax:**

**Email:**

**(02) 4925 2864**

**[intakeheadspacenewcastle@hunterprimarycare.com.au](mailto:intakeheadspacenewcastle@hunterprimarycare.com.au)**

**If you would like to discuss this referral please contact headspace Newcastle staff on (02) 4929 4201**