**Referral Form to headspace**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Young person’s details** | | |
| **Name:** | **DOB:** | **Age:** |
| **Gender:** | **Phone:** | **Whose number is this:** |
| **Address:** | **Town:** | **Postcode:** |
| **Does the young person identify as Aboriginal, Torres Strait Islander or Culturally & Linguistically Diverse?** | | |
| **Is this the preferred person to contact?** Yes / No | | |

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| **Next of kin details** | | |
| **Name:** | **Relationship:** | **Phone:** |
| **Address:** | **Town:** | **Postcode:** |
| **Is this the preferred person to contact?** Yes / No | | |

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| **Referrer details** | | |
| **Name:** | **Organisation:** | **Role:** |
| **Phone:** | **Email:** | **Fax:** |
| **Address:** | **Town:** | **Postcode:** |
| **Is this the preferred person to contact?** Yes / No | | |

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| **Current treating GP, if known** | | |
| **Name:** | **Practice:** | **Phone:** |

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| **Reason for referral** |
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| **History** |
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| **Current & previous service provision** | |
| **Is the young person currently involved with or have they recently been involved with any of the following services:** Please answer as Currently/Previously/Never/Unknown | |
| **Another headspace service** | Currently Previously Never Unknown |
| **Child & adolescent mental health service (CAMHS)** | Currently Previously Never Unknown |
| **Family & community services (FACS)** | Currently Previously Never Unknown |
| **Adult mental health services** | Currently Previously Never Unknown |
| **Psychologist** | Currently Previously Never Unknown |
| **Psychiatrist** | Currently Previously Never Unknown |
| **Paediatrician** | Currently Previously Never Unknown |
| **Other mental health/support/counselling services** | Currently Previously Never Unknown |
| **If yes is selected in any of the above, please provide details (please include any diagnosis &/or medications):** | |

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| **Risk assessment** | |
| **Have there ever been any concerns or is there any current concerns for the following:**  Please answer as Currently/Previously/Never | |
| **Suicidality** | Currently Previously Never |
| **Self-harm** | Currently Previously Never |
| **Homicidal ideation** | Currently Previously Never |
| **If current or previous risk concerns, please provide details:** | |

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| **Current risk level** |
| **Please select one:** Low (not urgent) / Moderate (not urgent) / High risk |
| **If young person is high risk or severely unwell they may not be best suited for headspace please contact the mental health hotline on 1800 011 511 (24hrs) for appropriate services** |

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| **Consent** | |
| **Is the young person aware of the referral?** | Yes / No |
| **Is the young person willing to attend an appointment?** | Yes / No |
| **Is the young person’s primary caregiver aware of the referral (where appropriate)?** | Yes / No |
| **Is the young person’s primary caregiver willing to attend the appointment?** | Yes / No |
| **If no has been selected for any of the above, please provide details:**  **Client Goals for seeing Headspace:** | |

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| **Any further information that supports your referral:** |
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| **Once referral is complete, please send to our office & our clinical team will review the referral and get back to you with a response.** |
| **headspace Orange**  264 Peisley Street, Orange NSW 2800.  Telephone (02) 6369 9300 Fax (02) 6369 9399  Email: [hs.orange@marathonhealth.com.au](mailto:hs.orange@marathonhealth.com.au)  ABN 86 154 318 97 |