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| *Please ensure all sections are completed and legible.**Return via* ***email:*** *headspace.Parramatta@Flourishaustralia.org.au**or* ***fax:*** *(02) 8331 6056* |
| **headspace Referral Criteria :** |
| headspace is a voluntary service for young people aged between 12 and 25. **We can only connect with Young People if they have consented to the referral and are in this age group.** |
| The Young Person has consented to and provided permission for a referral?  | Yes [ ]  | No [ ]  |
| Is the Young Person aged 12 to 25?  | Yes [ ]  | No [ ]  |
| **headspace is not a crisis service.** We are unable to support severe mental health concerns or crisis referrals. **We suggest you please call the Mental Health Line on 1800 011 511** if the young person requires urgent mental health assistance.**Please call headspace Parramatta on 1300 737 616 to ensure your referral has been received and to****discuss anything further. If we are unavailable, we will respond to you within three working days.**  |
| **Referrer Details:**  |
| Name of Referrer: |  |  |
| Relationship to Young Person: |  | Organisation: |  |
| Contact Number: |  | Fax: |  |
| Service Address: |  |
| Email: |  |
| Do you wish to be part of our mailing list?  | Yes [ ]  | No [ ]  |
| **Parent/Guardian/Carer:** \*  |
| Name: |  |
| Relationship to young person: |  | Contact Number: |  |
| Interpreter Required? Yes [ ]  No [ ] Do we have permission to speak with the person identified? Yes [ ]  No [ ]   |  |
| **Young Person’s Details:** \*please note that if the Young person is aged 15 and under, we will require a parent or guardian to be documented on this form.  |
| Name: |  |
| Date of Birth: |  | Age: |  | Gender: |  |
| Address: |  |
| Suburb: |  | Post code: |  |
| Contact Number 1: |  | 2. |  |
| Cultural Identity: |  | Language Spoken at home: |  |
| Preferred language: |  |  Interpreter needed:  | Yes [ ]  No [ ]  |
| Indigenous Identity:  | Aboriginal [ ]  | Torres Strait Islander [ ]  | Both [ ]  | Neither [ ]  |
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**Referral to headspace Parramatta**

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| **Primary reason(s) for Referral:** This section **must** be completed and/or assessment notes attached |
| [ ]  | **Mental Health Support**  Brief 1-3 sessions | [ ]  | **Physical Health Support**  |
| [ ]  | **Mental Health Support**  Focussed Psychological Interventions (MHCP/ATAPS) | [ ]  | **Vocation, Education, Training, Employment Support**   |
| [ ]  | **Alcohol and Other Drugs Support**  | [ ]  | **Groups Therapy**   [ ]   **Non-clinical Groups**   |
| **Presenting Issues:**  |
| Does the Young Person have a Mental Health Care Plan (MHCP)? Yes [ ]  No [ ]  |
| Can you support the Young Person to access a MHCP through a GP? Yes [ ]  No [ ]  |
| Please provide the Young Person’s Medicare card details where possible |
| Number:  |  | Reference Number: |  | Expiry Date: |  |
| **If the Young Person has a pre-existing diagnosis, please provide details.** This may include details of diagnosis, details of diagnosing health professional, previous treatment, etc. |
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| **Current presenting issues:**  |
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| **Other factors?** Is the Young Person currently undertaking or at risk of any of the following: |
| [ ]  Suicidal | [ ]  Harming self | [ ]  Harming others | [ ]  Extreme social withdrawal |
| [ ]  Homelessness | [ ]  Substance use | [ ]  School avoidance | [ ]  Other |
| Details: |  |  |
| Referrer Signature: |  | Date: |
| **Thank you! If you have any concerns please phone Intake on 1300 737 616.** |