headspace Referral Form

Referrer Details			
Referrer's name		Permission to contact referrer? Yes ☐ No ☐	
Relationship to YP		Is Young Person aware of referral? Yes ☐ No ☐	
Referrer's phone/email		Date of referral	
Young Person Details			
Name		DOB	
Address			
Mobile +/- Home		If we leave a message, can we say we are from headspace? Yes☐No☐	
Gender identity	Female ☐ Male ☐ non-Binary ☐ self-describe:		
Pronouns	She/Her ☐ He/Him ☐ They/Them ☐ self-describe:		
Cultural Identity			
Aboriginal ☐ Torres Strait Islander ☐ Aboriginal + Torres Strait Islander ☐			
non-Indigenous ☐ self-describe:			
Country of birth		Place of birth	
Which language are you most comfortable speaking in?			
Interpreter required? Yes ☐ No ☐		Interpreter specifics	
Emergency Contact Details			
Name			
Address			
Mobile		Home	
Relationship to Young Person		Can we contact this person about appointments? Yes ☐ No ☐	
Reason for referral			
Mental Health ☐ Drugs + Alcohol ☐ School / Work ☐ General Physical +/- Sexual Health ☐ Other ☐			
Can you please tell us a little more?			

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Additional Information (if known)	
Is the Young Person currently in crisis or at immediate risk to self or others? Yes ☐ No ☐ (headspace is not a crisis response service - please consider alternative referral if immediate support is required)	
Risk assessment (please indicate)	Self-harm ☐ Suicide Ideation ☐ Suicide attempt ☐ Violence/Aggression ☐ Psychosis/Mania ☐ Substance Use/Abuse ☐ Neglect/Abuse ☐ Homelessness ☐
Is the Young Person subject to any current court orders or VRO's? Yes ☐ No ☐	
Can you please tell us a little more?	
Preferred day +/- time of session with a headspace worker: Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Morning (8am-12pm) ☐Afternoon (12pm-4pm) ☐ Evening (4pm-6pm) ☐	

Involvement with other agencies/services		
GP Name + Practice		Is it ok to contact them? Yes ☐ No ☐
Psychologist/Counsellor details		Is it ok to contact them? Yes ☐ No ☐
Other		Is it ok to contact them? Yes ☐ No ☐
Other		Is it ok to contact them? Yes ☐ No ☐
Previous mental health treatment/diagnosis:		
Relevant medical details, including medications (please attach existing Mental Health Treatment Plan, discharge summary, other):		

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Client Consent			
I have discussed headspace Pilbara services with the referring agency (where applicable) Yes ☐ No ☐			
I have agreed to accept headspace Pilbara services Yes ☐ No ☐			
I am aware that this referral is being made and a headspace worker will be phoning me or my parent/guardian to discuss Yes ☐ No ☐			
I understand I can withdraw from headspace Pilbara anytime Yes ☐ No ☐			
Young Person's name		Date	
Young Person's signature			
Consent Method	Verbal ☐ Written ☐		
If the young person is **under 16 years of age**, authorisation should, **where possible,** be provided by a parent/guardian/carer.			
Guardian name		Date	
Guardian signature			

queries / to chat with headspace regarding this referral : 1800 290 626

what happens next?

1. Email this completed referral form to the below addresses; dependant on location of Young Person:

headspace Karratha | info@headspacekarratha.org.au
Karratha
headspace Hedland | info@headspacehedland.org.au
Port Hedland + South Hedland
headspace Pilbara | info@headspacepilbara.org.au
Newman, Tom Price, Roebourne, Wickham, Onslow, Pannawonica, Paraburdoo, Marble Bar, Nullagine, Yandeyarra + Western Desert Communities

2. If we require further information from you, we will make contact
3. If we do not require information from you, please know that this referral will be triaged + assessed by our Clinical Team within 2 working days. We will contact the Young Person regarding the outcome of the referral and collaborate with any other person or service the Young Person has consented too moving forward. Generally, an initial appointment will be offered for the Young Person to meet with a headspace worker and engage in further assessment. If the referral is assessed to be outside our service model, we will contact yourself + the Young Person to suggest alternative support options.