

# headspace Port Adelaide / Thrive Referral Form

Fax to (08) 8312 3025 or email to [headspaceportadelaide@centacare.org.au](mailto:headspaceportadelaide@centacare.org.au)



Date:	Time:
Name of person filling in this form:	<input type="checkbox"/> Email/Fax <input type="checkbox"/> In person <input type="checkbox"/> Phone
Is this referral for:	
<input type="checkbox"/> headspace Port Adelaide <i>Early intervention, short-medium term mental health support for young people aged 12-25 experiencing <b>mild to moderate</b> mental health difficulties.</i>	
<input type="checkbox"/> Thrive <i>Mental health support for young people aged 16-25 experiencing, or at risk of developing, <b>severe and/or complex</b> mental health needs and/or eating disorders.</i>	

Young Person Details				
Please confirm young person is aware of and consents to referral: <input type="checkbox"/> Yes				
Name				
Date of Birth		Age	Gender	
Residential Address				
Contact Details	Phone:	Email		
Preferred mode of contact	<input type="checkbox"/> SMS <input type="checkbox"/> Phone call <input type="checkbox"/> Email <input type="checkbox"/> Letter			
Does the young person require support with reading and writing? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Does the young person have a Mental Health Care Plan: <input type="checkbox"/> No <input type="checkbox"/> Yes			Medicare card number:	
Does this young person have a formal mental health diagnosis: <input type="checkbox"/> No <input type="checkbox"/> Yes			Reference	Expiry date:
Young Person's Cultural Identity	<input type="checkbox"/> Aboriginal	<input type="checkbox"/> Torres Strait Islander	<input type="checkbox"/> Culturally and Linguistically Diverse	<input type="checkbox"/> None of these
Would the young person prefer to see an Aboriginal worker?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Does the young person require an interpreter?	<input type="checkbox"/> No <input type="checkbox"/> Yes - language: _____			

Family and Friends Contact	
Name	
Relationship to young person:	
Contact Details	Email
Consent to contact in an emergency:	<input type="checkbox"/> Yes <input type="checkbox"/> No

For headspace Port Adelaide Referrals only Reason for Referral (tick as many as apply)	
<input type="checkbox"/> Mental health support	<input type="checkbox"/> Physical health support
<input type="checkbox"/> Alcohol and other drugs support	<input type="checkbox"/> Work & study support
<input type="checkbox"/> Financial counselling	<input type="checkbox"/> Independent housing support

For Thrive Referrals only – please note that service providers are encouraged to call and speak to the Thrive team before making a referral where possible. Referral Criteria (all must apply)	
Age 16-25 <input type="checkbox"/> Yes	
Resides in Adelaide's Western suburbs <input type="checkbox"/> Yes	
Experiencing or at risk of experiencing a <b>severe and/or complex</b> mental illness <input type="checkbox"/> Yes	
Requires a mix of multi-disciplinary, multi-agency approaches to meet their mental health care needs <input type="checkbox"/> Yes	
Seeking support for a diagnosis of/risk of diagnosis of at least one of the following:	
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Severe Anxiety Disorder
<input type="checkbox"/> Bipolar Affective Disorder	<input type="checkbox"/> Borderline Personality Disorder
<input type="checkbox"/> Post-Traumatic Stress Disorder	<input type="checkbox"/> Severe Depressive Disorder
<input type="checkbox"/> Psychosis (referrals for first episode of psychosis should be instead directed to headspace Youth Early Psychosis Program at <a href="https://headspace.org.au/headspace-centres/adelaide/">https://headspace.org.au/headspace-centres/adelaide/</a> )	

**Consent**

I, [carer's name if young person under 16, young person's name if 16 or over], give consent for this referral to be made and give permission for [referrer name] to exchange information with **headspace** Port Adelaide / Thrive for the purpose of this referral.

Young person/carer signature:

Date:

Referrer Detail

**Source of Referral:**

Referring Person			
Address/ Agency			
Phone:	Mobile	Fax	Email
Relationship/Position			

**Referring worker's name and signature**

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

Please note that **headspace** Port Adelaide/Thrive are not crisis services. Crisis care can be accessed via Western CAMHS (<16) on (08) 8161 7000 or Mental Health Triage (>16) on 13 14 65

<b>Office Use Only Medicare Checks</b>			
<b>MHCP</b> Current Y/N	Date of Visits Left	<b>GP Care Plan</b> Current Y/N	Date of Visits Left