|  |
| --- |
| **hsPort Lincoln Referral Form** |

|  |
| --- |
| **Young Person’s Details** |
| Name |  | DoB |  |
| Preferred Name |  |
| Gender |  | Pronouns |  |
| Home Address |  |
| Postal Address |  |
| Is it ok for us to send headspace branded documents to this address? | [ ]  Yes [ ]  No |
| Contact |  | Is it ok to contact via SMS? | [ ]  Yes [ ]  No |
| Email |  | Is it ok to contact via email? | [ ]  Yes [ ]  No |
| Is the young person subject to any guardianship or custody orders? | [ ]  Yes [ ]  No |
| Details |  |
| Culture | [ ]  Aboriginal | [ ]  Torres Strait Islander | Other: |
| Need an interpreter? | [ ]  Yes [ ]  No | Language: |

|  |
| --- |
| **Emergency Contact** *(must be at least 18 years old)* |
| Consent to share information with them? | [ ]  Yes [ ]  No |
| Name |  | Contact |  |
| Relationship |  |

|  |  |
| --- | --- |
| **Referrer Details** | [ ]  Self-Referral |
| Referrer Name |  | Organisation |  |
| Contact |  | Fax |  |
| Email |  |
| Relationship to young person |  |

|  |
| --- |
| **Medical** |
| Existing GP? | [ ]  Yes [ ]  No | Treatment Plan? | [ ]  Yes [ ]  No |
| GP Name |  | Surgery |  |
| Contact |  |

|  |
| --- |
| **Reason for Referral** *(What are the current issues and what support is needed? Please include info about the duration, age of onset and pre-existing diagnoses. Please attach further information/relevant assessments, reports, etc)* |
|[ ]  **Mental Health Support** |
| [ ]  Sad/Depressed | [ ]  Anger | [ ]  Questioning Gender/Sexuality |
| [ ]  Anxious/Stressed | [ ]  Family/Friendship Problems | [ ]  Other Challenges |
| Details: |
|[ ]  **Work and Study Support** |
| Details: |
|[ ]  **Alcohol and other Drugs Support** |
| Details: |
|[ ]  **Physical and Sexual Health Support** |
| Details: |

|  |  |  |
| --- | --- | --- |
| **Risk Factors *(self / referrer to complete)*** | **Present in last 4 weeks** | **Past Concern** |
| Suicidal thoughts | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| Suicidal behaviour (plans/intentions to act) | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| Deliberate self-harm | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| Thoughts of harming other people | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| Hospital presentation (mental health) | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| If selecting ‘Yes’ to suicidal thoughts and/or self-harm, is there a safety plan? | [ ]  Yes [ ]  No |
| Details: |

|  |
| --- |
| **Any Other Relevant Information** |
|  |

|  |
| --- |
| **Important Information About the Referral – Please Read** |
| headspace provides free and confidential services for young people aged between 12-25 years, who consent to receiving support. headspace is not a crisis service, if the young person is in crisis or are at acute risk of harming themselves or others, please contact emergency services on 000.In a mental health emergency please contact Mental Health Triage on 13 14 65 (16+ years) or Kids Helpline 1800 55 1800. Once a referral form has been received the headspace team will contact you.**Waitlist** - given the demand for headspace services, there may be a waitlist at times. You will be advised by a headspace staff member via phone call or letter. Please seek support from your GP or local hospital should your situation change. We recommend a list of services including eheadspace and Beyond Blue. |

|  |
| --- |
| **Young Person Supports & Consent** |
| Does the Young Person consent to the referral? | [ ]  Yes [ ]  No |
| If under 16, do parents/carers consent to the referral? | [ ]  Yes [ ]  No |
| Parent/Carer Name 1 |  | Signature |  |
| Parent/Carer Name 2 |  | Signature |  |

*Please complete the referral and email it to* *hsplReception@youturn.org.au* *or drop it into our office*