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| **hsPort Lincoln Referral Form** |

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| **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: | | | | |

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

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

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

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| **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: | | | |

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| **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: | | |

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| **Any Other Relevant Information** |
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| **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. |

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| **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*](mailto:hsplReception@youturn.org.au) *or drop it into our office*