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| **hsPort Lincoln Referral Form** |

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| **Referrer Details** |
| Name |  | Referral Date |  |
| Position |  | Ongoing Involvement | [ ]  Yes | [ ]  No |
| Service |  |
| Contact |  | Email Address |  |

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| **Young Person’s Details** |
| *Completion of this referral indicates consent has been given by the young person and their parent/guardian if the young person is under 16 years old.* |
| Preferred Name |  |
| Birth Name |  |
| Date of Birth |  |
| Address |  |
| Gender | [ ]  Male | [ ]  Female | [ ]  Non-binary | [ ]  Transgender |
| [ ]  Prefer not to say | [ ]  Other: |
| Preferred Pronouns |  |
| Contact Number |  |
| Consent from young person to call or send SMS | [ ]  Yes | [ ]  No |

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| **Next of Kin** *(must be 18 years old or over)* |
| Name |  |
| Relationship to young person |  |
| Contact Number |  |
| Consent to liaise with NOK | [ ]  Yes | [ ]  No |
| **Parent/Guardian** |
| Name |  |
| Contact Number |  |

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| **Reason for Referral** |
| [ ]  Mental Health | [ ]  Education Barriers | [ ]  Conduct Difficulties |
| [ ]  Sexuality/Gender | [ ]  Drug & Alcohol | [ ]  Work & Study |
| [ ]  Policy Involvement | [ ]  Friendships/Social | [ ]  Physical and/or Sexual Health |
| [ ]  Risk of Homelessness | [ ]  Family Conflict | [ ]  Relationship Concerns |
| [ ]  Grief & Loss | [ ]  Trauma (*please note: we provide early intervention support)**(Have you considered other specialised referral pathways?)* |
| Other:  |
| **Additional Referral Information** |
| *This must be completed for the referral to be accepted* |
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| Risk |
| Is the young person currently suicidal? | [ ]  Yes [ ]  No |
| *If Yes, please consider referring to Child and Youth Mental Health or Adult Mental Health and/or phone headspace to discuss referral* |
| Are there additional risk areas identified for the young person? | [ ]  Yes [ ]  No |
| *If Yes, please provide additional details:* |
| Were additional referral/s made? | [ ]  Yes [ ]  No |
| *If Yes, please outline:* |
| If a referral has been made to another mental health/counselling service, please outline why an additional referral has been made to headspace |  |

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| **headspace Contact Details** |
| headspace Port Lincoln2/7 Mortlock Terece, Port Lincoln, South AustraliaPh (08) 7081 3616Fax (08) 7081 3616Email – hsplreception@youturn.org.au |