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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 Lincoln  2/7 Mortlock Terece, Port Lincoln, South Australia  Ph (08) 7081 3616  Fax (08) 7081 3616  Email – [hsplreception@youturn.org.au](mailto:hsplreception@youturn.org.au) |