Referral to headspace Redcliffe

On completion of this form, please email to: headspace.Redcliffe@openminds.org.au, or fax to: 07 3897 1800, or post to: PO Box 636, Redcliffe QLD 4020

Important information regarding your referral, please read:

- headspace Redcliffe is a service for young people between the ages of 12 to 25. We can only engage with young people who have provided consent to the referral.
- If the young person is at high or acute risk of suicide, please contact emergency services on 000.
- Please note that receipt of the referral form does not indicate acceptance to the headspace Redcliffe services. Suitability of the referral will be determined following assessment with the young person. Please call headspace Redcliffe to confirm receipt and discuss the outcome of your referral.
- To complete the referral, you must attach relevant assessment notes, discharge summaries and/or additional information.
- We will endeavour to respond to referrals within 24-48 hours if received during business hours.

Consent for referral:
Has the young person consented to and provided permission to exchange information in relation to this referral? ☐ Yes ☐ No

Primary reason(s) for Referral: This section must be completed. Please contact us if you have any queries regarding available services.

☐ Short-term Mental Health Intervention with headspace Redcliffe Primary Care Team

Does the young person have a Mental Health Care Plan? ☐ Yes ☐ No

☐ Drug and/or Alcohol Support ☐ Vocational Support

☐ Physical Health Support ☐ Other, please specify ______________________

Referrer details: headspace will be corresponding with you using the below details. Please ensure that all details listed below are correct and legible.

Name of Referrer: Click here to enter text. Organisation: Click here to enter text.
Relationship to Young Person: Click here to enter text. Designation: Click here to enter text.
Contact Number: Click here to enter text. Fax Number: Click here to enter text.
Service Address: Click here to enter text.
Email Address: Click here to enter text.
Do you wish to be part of our mailing list? ☐ Yes ☐ No

Parent/guardian: Please note that if the young person is aged 16 and under, we will require a parent or legal guardian to be documented on this form and attend the first appointment.

Name: Click here to enter text.
Relationship to young person: Click here to enter text. Contact Number: Click here to enter text.
Do we have permission to speak with the person identified? ☐ Yes ☐ No
# headspace Redcliffe Referral Form

## Young Person’s Details:

<table>
<thead>
<tr>
<th>Field</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Click here to enter text. Age: Click here to enter text. Gender: Click here to enter text.</td>
</tr>
<tr>
<td>Address</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Suburb</td>
<td>Click here to enter text. Post code: Click here to enter text.</td>
</tr>
<tr>
<td>Contact Number 1</td>
<td>Click here to enter text. 2. Click here to enter text.</td>
</tr>
<tr>
<td>Medicare Card Details</td>
<td>[ ] Expiry Date: [ ]</td>
</tr>
<tr>
<td>Interpreter Required?</td>
<td>[ ] Yes, Language: [ ] [ ] No</td>
</tr>
<tr>
<td>Assistance with Reading/Writing?</td>
<td>[ ] Yes [ ] No</td>
</tr>
</tbody>
</table>

## Presenting Issues:

**Current presenting issues (please include duration, age of onset, and relevant pre-existing diagnoses):**

Click here to enter text.

**Impact of problem on functioning:** (e.g. relationships/school/home/work)

Click here to enter text.

**Please indicate if there is any known family history of mental health conditions:**

Click here to enter text.

**Previous/current engagement with other services:** (if current and referrer, assessment information must be attached)

Click here to enter text.
Risk Factors:

- [ ] Suicide
- [ ] Non-accidental self-injury
- [ ] Harm to others
- [ ] Extreme social withdrawal
- [ ] Homelessness
- [ ] Substance use
- [ ] Accidental Death
- [ ] Non-compliance

Please provide details:

Click here to enter text.

Referrer’s Signature/Name: __________________________

By signing this document, the referrer agrees that the above information is a true and accurate record.

Date: __________________________

OFFICE USE ONLY

When booking appointment, please request that the YP attends 15 minutes prior to their appointment time

- [ ] Book with Intake Clinician  Date/Time: __________________________  Clinician: __________________________
- [ ] Declined/Referred Elsewhere  Recommendations Made:  Click here to enter text.