Referral to headspace Redcliffe

On completion of this form, please
email to: headspace.Redcliffe@openminds.org.au,
or
fax to: 07 3053 3495, 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:	Organisation:
Relationship to Young Person:	Designation:
Contact Number:	Fax Number:
Service Address:	
Email Address:	
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:	
Relationship to young person:	Contact Number:
Do we have permission to speak with the person identified? ☐ Yes ☐ No	

Young Person's Details:

Name:

Date of Birth: Age: Gender:

Address:

Suburb: Post code:

Contact Number 1: 2.

Medicare Card Details: Expiry Date:

Interpreter Required? ☐ Yes, Language: ☐ No

Assistance with Reading/Writing? ☐ Yes ☐ No

Presenting Issues:

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

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

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

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

Risk Factors:

☐ Suicide withdrawal ☐ Non-accidental self-injury ☐ Harm to others ☐ Extreme social

☐ Homelessness ☐ Substance use ☐ Accidental Death ☐ Non-compliance

Please provide details:

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: