

headspace Rockhampton Referral Form

Once completed please email to: headspacerocky@roseberry.org.au

For any queries, please contact (07) 4911 6040.



headspace is an early intervention and prevention service. If the young person is experiencing high levels of distress which may result in harm to themselves or others, they are not suitable for headspace services. Please contact 1300 MH CALL on 1300 642255 (24 hours) to speak with a registered nurse, take them to your nearest hospital, or call 000.

Important information regarding your referral, please read:

- headspace Rockhampton is an **early intervention** and **prevention** service for young people between the ages of **12 to 25** who have mild-moderate mental health concerns. We can only engage with young people who have provided **consent** to the referral.
- Please note when a referral is received, it does not indicate acceptance to headspace Rockhampton's services. Once the referral is reviewed, we will be in touch to either offer an initial appointment or discuss who might be a more appropriate care service to support the young person.
- From there, our team will be in touch within **7 days** to let you know the outcome of the referral.

Does the young person know about this referral?	☐ Yes ☐ No – <i>if no, please gain consent, we can only engage with young people who have provided consent to the referral.</i>				
Is the young person between 12-25 years of age?	☐ Yes ☐ No – <i>if no, the referral cannot be accepted. Get in touch and we'll talk you through some other options.</i>				
Young Person's details:					
Full Name:					
Preferred Name:		Date of Birth:		Age:	
Gender:			Pronouns:		
Residential Address:					
	Suburb		Postcode		
Contact Number:			Safe to leave a message?	☐ Yes ☐ No	
Email (optional):					
Cultural Background:					
Assistance with Reading or Writing?	☐ Yes ☐ No				
Is an interpreter required?	☐ Yes ☐ No				
Do they have a regular GP? If yes, who?					

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Name of Person Referring:	
Who is referring?	☐ Self ☐ Service Provider ☐ Family/Friend ☐ Other: _____
Name:	
Position / Relationship to Young Person:	
Contact Number:	
Email Address:	
Who is the primary contact person for this referral:	

Parent/Guardian/Next of Kin: We will contact your next of kin in the case of emergency			
Name:			
Relationship:		Contact Number:	

Primary Reason(s) for Referral: This section <u>must</u> be completed. Please contact us if you have any questions regarding available services.	
☐ Short-term Mental Health Intervention for mild-moderate mental health concerns Does the young person have a current GP Mental Health Treatment Plan? ☐ Yes ☐ No	
☐ Drug and/or Alcohol Support	☐ Work/Study Support
☐ Physical Health Support	☐ Other, please specify: _____

Presenting Issues:	
What led to the referral to headspace? What are the current concerns? (please include duration, age of onset, and relevant pre-existing diagnoses):	
☐ Bullying ☐ Depression ☐ Disordered Eating	☐ Relationships ☐ Sexuality or Gender Identity ☐ Conflict in Home Environment
☐ School ☐ Social Concerns ☐ Work & Study	☐ Anxiety ☐ Sleep ☐ Other _____

Risk Factors:

- | | | | |
|---|---|---|--|
| ☐ Suicide | ☐ Harm to others | ☐ Deliberate self-harm | ☐ Accidental death |
| ☐ Social Isolation | ☐ Substance Use | ☐ Homelessness | ☐ Social Withdrawal |
| ☐ Domestic and Family Violence | ☐ Child Safety Involvement | ☐ Non-compliance | ☐ Other _____ |

Please provide details and attach current safety plan (if applicable):

Any previous mental health support/treatment, counselling, medication, or diagnoses?

Is the young person currently engaged with any supports, or have they also been referred elsewhere?

How does the young person feel about coming to headspace? How motivated are they to attend?

What do you hope headspace Rockhampton can achieve for this young person?

Consent: Where possible, have the young person sign this referral. If verbal consent is obtained, please ensure the following information is provided to the young person and consent for below is given.

I am aware that this referral is being made. I understand that I can withdraw from this referral or from the referred service at any time.

I give permission for headspace Rockhampton to use my contact details above for future contact with me ☐ Yes ☐ No

If someone is referring me to headspace Rockhampton, I give permission for the staff of headspace Rockhampton to obtain relevant information from referrer pertaining to this referral ☐ Yes ☐ No

I understand that headspace Rockhampton will provide the referrer listed on this referral, feedback of the outcome of the referral and intake assessment at headspace Rockhampton. This will only include intake attendance/non-attendance and outcome, not specific content discussed during an intake appointment.

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Young Person's Signature:		Date:	
Referrer's Signature:		Date:	

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All referrals received are reviewed and actioned within 7 days.