headspace Southport
Referral Form

Please return completed form to:
Email:reception@headspacesouthport.org.au
Phone: 07 5509 5900 **Fax**: 07 5527 1251
All enquires are welcome

PRIMARY REASON (S) FOR REFERRAL

Mental Health ☐ Alcohol/Drug Use ☐ Physical ☐ Vocational ☐
Other ☐
Groups Only ☐
Short-term mental health intervention with **headspace** Primary Care Team ☐
Assessment with **headspace Early Psychosis Program** ☐

PERSON BEING REFERRED (THESE DETAILS WILL BE USED TO CONTACT THE YOUNG PERSON / PARENT, GUARDIAN)

First Name:		Last Name:			
Date of Birth:		Gender:		Pronouns:	
Primary Mobile Contact & Name:		Secondary Phone Contact & Name:			
Email:					
Address:					
Language Preferred:					
Parent/ Guardian Name and Contact Number: (if consent given by young person)					

AUTHORISATION OF REFERRAL BY PERSON BEING REFERRED

Please NOTE: Referrals will not be processed without signed consent.

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** Southport to use my contact details above for future contact with me.
Yes ☐ No ☐

I give permission for the **staff** of **headspace** Southport to obtain relevant information from government and non-government agencies, from doctors and other health professionals specifically relevant to my care whilst being a client of **headspace** Southport.

Signed			
Print Name:		Date:	

If under 16 years of age consent is required by a parent/ guardian.

Signed			
Parent/Guardian Name:			
Relationship:		Date:	

headspace National Youth Mental Health Foundation is funded by the Australian Government Department of Health

REFERRER (INDIVIDUAL COMPLETING THIS DOCUMENT)

Contact Name:			
Position / Relationship:			
Organisation (if applicable):			
Phone:		Mobile:	
Email:		Fax:	
Signed:			

PRESENTING ISSUES

- ☐ ADHD / ADD
- ☐ ALCOHOL ABUSE
- ☐ ANXIETY
- ☐ ASPERGERS
- ☐ AUTISM
- ☐ BODY IMAGE
- ☐ BULLYING OTHERS
- ☐ CRYING
- ☐ DEPRESSION
- ☐ DIFFICULTY SLEEPING
- ☐ DOCS
- ☐ DOMESTIC VIOLENCE
- ☐ DRUG USE
- ☐ EATING PROBLEMS
- ☐ EMOTIONAL ABUSE
- ☐ FAMILY PROBLEMS
- ☐ FINANCIAL DIFFICULTY
- ☐ FUNCTIONAL DECLINE
- ☐ OTHER (PLEASE DESCRIBE)
- ☐ HARM OR THREATS TO OTHERS
- ☐ HALLUCINATIONS AND DELUSIONS
- ☐ HISTORY OF HOSPITALISATION
- ☐ INTELLECTUAL DISABILITY
- ☐ LOSS OF APPETITE
- ☐ LOW SELF ESTEEM
- ☐ PENDING LEGAL MATTERS
- ☐ PAIN MANAGEMENT ISSUES
- ☐ PHYSICAL ABUSE
- ☐ PHYSICAL DISABILITY
- ☐ PTSD
- ☐ REFUSING SCHOOL
- ☐ RELATIONSHIP ISSUES
- ☐ SEXUAL ABUSE
- ☐ SELF HARM
- ☐ SOCIAL PROBLEMS AT SCHOOL
- ☐ STRESS
- ☐ SUICIDAL
- ☐ TRAUMA HISTORY

CAN YOU TELL US MORE? (ABOUT THE BOXES TICKED ABOVE)

RISK TO SELF OR OTHERS (INCLUDE SELF HARM, SUICIDE ATTEMPTS, VIOLENCE, THREATS OF VIOLENCE)

Date(s):		Type of Behaviour:	
Reason for Behaviour:			
Outcome/ Treatment: Provided			

OTHER AGENCIES/HEALTH CARE PROVIDERS CURRENTLY INVOLVED WITHIN THE YOUNG PERSON'S CARE (IE. GOVERNMENT, NON-GOVERNMENT, GP'S, PSYCHIATRISTS AND COMMUNITY SERVICES)

Contact Person:			
Organisation:		Phone:	
Email:			

Contact Person:			
Organisation:		Phone:	
Email:			

ELIGIBILITY CRITERIA:

- Referrals from QLD Health require a copy of ALL relevant collateral information (including assessment, discharge summaries & recovery documents).

- Referrals from Probation and Parole require information on convictions and pending legal matters including dates, along with AOD information prior to referral being processed.

- Referrals for "groups only" need to include a clearly identified functional recovery goal to be achieved by attending the group program prior to the referral being processed.

Please **fax** or **email** referral form to: (07) 55 271 251 or reception@headspacesouthport.org.au
For more information please call: (07) 5509 5900