headspace Whyalla Referral form

YOUNG PERSON DETAILS		
Name: Preferred Name:	Date of Birth: Age:	Gender Male ☐ Female ☐ Other ☐
Address:	Phone: Email:	SMS reminders? Y ☐ N ☐ Preferred contact number:
Aboriginal ☐ Torres Strait Islander ☐ Other…… ☐	Cultural Identity: Language:	Best method of contact: Mobile: ☐ Email: ☐

Does the young person consent to the referral? Yes ☐ No ☐

If under 16, does a parent or carer consent to the referral? Yes ☐ No ☐

Involvement of significant other? Yes ☐ No ☐ Who: _____

****EMERGENCY CONTACT (REQUIREMENT)**

Name: Phone: Relationship to Young Person:

REFERRER DETAILS		
Name	Phone Fax	Email
Address	Organisation	Relationship to young person

DOES THE YOUNG PERSON HAVE AN EXISTING GP? Yes ☐ No ☐ Mental Health Treatment Plan ☐

GP Name	Surgery	Phone

PRESENTING ISSUES: (*this must be completed*)

Mental Health _____

Physical Health _____

Sexual Health _____

Family _____

Relationships _____

School/ work _____

Accommodation _____

Justice issues _____

Drug & Alcohol _____

Other _____

RISK FACTORS

Risk to self Yes ☐ No ☐
History of self harm Yes ☐ No ☐
Intent/ Plan Yes ☐ No ☐
Management Plan:

Risk to others Yes ☐ No ☐
Suicidal ideation Yes ☐ No ☐

YOUNG PERSON SUPPORTS & STRENGTHS

Does the young person receive support from other agencies? Yes ☐ No ☐

Please list the agencies: _____
& Others (family, friends)

_____

_____

Strengths: _____

_____

YOUNG PERSON AND CARER CONSENT FOR REFERRAL AND INFORMATION

I (young person)_____ being **16 years or older** agree to be referred to and engage in services at headspace Whyalla and give my permission for (referrers name) _____ to provide and receive written and verbal information from headspace Whyalla for the purpose of the referral.

I (carer) _____ agree for (young person **under the age of 16**) _____ to be referred to and engage in services at headspace Whyalla and for information to be shared as above.

Young person signature..... Date
Carer signature..... Date
Referrer signature..... Date

REFERRAL OUTCOME (office use only)

Eligible for headspace services? Yes ☐ No ☐ Rationale: _____

Referrer notified : _____

Referred to other service: _____

Appointment date & time: _____ Worker: _____

Actions Required: _____

Please complete referral and fax to headspace Whyalla on 8641 4399 or phone 8641 4330 or drop in to our office at 24-26 Ekblom Street, Whyalla Norrie (back of Doctors @ Westlands)