headspace Woolloongabba

referral form

ELIGIBITY CRITERIA:

- **Referral from Service Providers** **will require a copy of ALL relevant collateral information** *(including any assessments, discharge summaries and recovery documents)* **prior to the referral being triaged**.
- **General Practitioners** can fax and/or email a Mental Health Care Plan to headspace Woolloongabba instead of completing this referral form
- **Referrals from Probation and Parole** require social history, information on convictions and pending legal matters including dates, **prior to referral being triaged**. Please note we are a voluntary service.
- All referrals will be triaged by the Clinical Team to assess eligibility and suitability for headspace Woolloongabba
- Outcome of referral will be provided directly to Service Provider via email, telephone and/or fax
- headspace Woolloongabba works **under the Medicare Billing Model (MBS)**, which means young people are **eligible for up to 10 Sessions** with Private Practitioners (Psychologists, Social Workers, Occupational Therapists) per calendar year
- headspace Woolloongabba also has access to **Psychological Therapies Program** Practitioners (Psychologists, Social Workers, Occupational Therapists) onsite where a young person can access up to 12 sessions if assessed to meet the criteria by the Clinical Team
- For further information on services available at headspace Woolloongabba please access our website

1. REFERRER (INDIVIDUAL COMPLETING THIS DOCUMENT)

Contact Name:

Position / Role:

Organisation:

Postal Address: Post Code:

Phone: Mobile: Fax:

Email:

Signed:

2. YOUNG PERSON BEING REFERRED (THESE DETAILS WILL BE USED TO CONTACT THE YOUNG PERSON / PARENT, FAMILY MEMBER, CARER)

First Name: Surname:

Date of Birth: Age: Gender:

Address:

Suburb: Post Code: State:

Home Phone: Mobile:

Email:

If consent provided by young person, please provide details of their Parent / Family Member / Carer

Name: Relationship to young person:

Mobile:

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

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NOTE TO REFERRER

Please provide as much information as possible as it ensures the best quality of care, outcome and if required referral is afforded to the young person being referred.

If the young person is experiencing high levels of distress which may result in harm to themselves or others, please refer them directly to their local Emergency Department as headspace is not a Crisis Service or equipped to manage these types of emergencies.

3. REASON FOR REFERRAL

Mental Health

Physical Health

Vocational / Social

Alcohol / Other Drugs

headspace Early Psychosis

Other (please specify): ______________________

4. INFORMATION ABOUT THE YOUNG PERSON

Risk to self or others: *(If Applicable)*
(Include self-harm/suicide attempts, violence, threats of violence, vulnerability, child safety orders)

DATE	PRESENTING ISSUE	PREVIOUS TREATMENT	CURRENT TREATMENT

Other Agencies / Health Care Providers who are currently involved with the Young Persons Care: *(If Applicable)*
(e.g. Government, Non-Government, Psychiatrists, GP's and Community Services)

NAME OF ORGANISATION	CONTACT PERSON	ADDRESS	PHONE

5. PRESENTING ISSUES

ADHD / ADD

AGGRESSION

ALCOHOL MISUSE

ANXIETY

AUTISM SPECTRUM DISORDER

BODY IMAGE CONCERNS

BULLYING

CONTACT WITH CHILD SAFETY

DEPRESSION

DOMESTIC VIOLENCE

DRUG MISUSE

EATING ISSUES

EMOTIONAL ABUSE

EMPLOYMENT DIFFICULTIES

FAMILY DIFFICULTIES

FINANCIAL DIFFICULTIES

INTELLECTUAL DISABILITY

OBSESSIVE COMPULSIVE BEHAVIOURS

CONTACT WITH CHILD SAFETY

OTHER

PENDING LEGAL MATTERS

PHYSICAL ABUSE

PHYSICAL DISABILITY

PRESENTATION TO E.D.

PSYCHOSIS

PTSD / TRAUMA HISTORY

RELATIONSHIP ISSUES

SCHOOL REFUSAL

SELF-HARM

SEXUAL ABUSE

SOCIAL DIFFICULTIES

STRESS

SUICIDAL

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Please provide relevant information:

6. CONSENT OF YOUNG PERSON BEING REFERRED

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.

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

I give permission	for headspace Woolloongabba to use my contact details above for future contact with me.	Yes	No
I give permission	for the **staff** of headspace Woolloongabba to obtain relevant information from referrer pertaining to this referral	Yes	No
I give permission	for headspace Woolloongabba to contact the referrer and advise once an appointment has been arranged.	Yes	No

Signed: ____________ Print Name: ____________ Date: ____________

If under 18 years of age authorisation ideally should be provided by a parent/guardian.

Parent / Guardian Signed: ____________ Print Name: ____________

Relationship: ____________

7. THANK YOU FOR YOUR REFERRAL

Please return this form to headspace Woolloongabba

Ph: 07 3249 2222

Fax: 07 3038 3090

Email: headspace.Woolloongabba@stride.com.au

NEW Address: 66 Annerley Road, Woolloongabba, QLD 4102.

8. WHAT NEXT?

- On receipt of a referral headspace Woolloongabba will contact the service provider to advise of outcomeand then if applicable will contact the young person for a phone triage and/or in addition to arrange a face toface appointment.
- All triage contact will be with a headspace Woolloongabba Intake Clinician.

headspace Woolloongabba is operated by Stride

Privacy is important to us, the information on this form will be kept confidential in line with headspace and Stride policies.

- headspace Privacy Policy: headspace.org.au/privacy-policy
- Stride Privacy Policy and Statement: stride.com.au/privacy-policy

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