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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referrer Details** | | | | | | | | | | | | | | | | | |
| Referrer’s name | | | | |  | | | | | | | | Permission to contact referrer? Yes ☐ No ☐ | | | | |
| Relationship to YP | | | | | |  | | | | | | Is Young Person aware of referral? Yes ☐ No ☐ | | | | | |
| Referrer’s phone/email | | | | | | |  | | | | | | | Date of referral | | | |
| **Young Person Details** | | | | | | | | | | | | | | | | | |
| Name |  | | | | | | | | | | | | | | | DOB |  |
| Address |  | | | | | | | | | | | | | | | | |
| Mobile +/- Home | | | | |  | | | | If we leave a message, can we say we are from headspace? Yes☐No☐ | | | | | | | | |
| Gender identity | | | | | Female ☐ Male ☐ non-Binary ☐ self-describe: | | | | | | | | | | | | |
| Pronouns | | | She/Her ☐ He/Him ☐ They/Them ☐ self-describe: | | | | | | | | | | | | | | |
| **Cultural Identity** | | | | | | | | | | | | | | | | | |
| Aboriginal ☐ Torres Strait Islander ☐ Aboriginal + Torres Strait Islander ☐ | | | | | | | | | | | | | | | | | |
| non-Indigenous ☐ self-describe: | | | | | | | | | | | | | | | | | |
| Country of birth | | | |  | | | | | | | Place of birth | | | |  | | |
| Which language are you most comfortable speaking in? | | | | | | | | | | | | | | | | | |
| Interpreter required? Yes ☐ No ☐ | | | | | | | | | Interpreter specifics | | | |  | | | | |
| **Emergency Contact Details** | | | | | | | | | | | | | | | | | |
| Name | |  | | | | | | | | | | | | | | | |
| Address | |  | | | | | | | | | | | | | | | |
| Mobile | |  | | | | | | | | | | | Home | |  | | |
| Relationship to Young Person | | | | | | | |  | | Can we contact this person about appointments? Yes ☐ No ☐ | | | | | | | |
| **Reason for referral** | | | | | | | | | | | | | | | | | |
| Mental Health ☐ Drugs + Alcohol ☐ School / Work ☐ General Physical +/- Sexual Health ☐ Other ☐ | | | | | | | | | | | | | | | | | |
| Can you please tell us a little more? | | | | | | | | | | | | | | | | | |

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| **Additional Information (if known)** | | | | | |
| **Is the Young Person currently in crisis or at immediate risk to self or others?** Yes ☐ No ☐  (headspace is not a crisis response service - please consider alternative referral if immediate support is required) | | | | | |
| Risk assessment (please indicate) | | | | Self-harm ☐ Suicide Ideation ☐ Suicide attempt ☐ Violence/Aggression ☐ Psychosis/Mania ☐ Substance Use/Abuse ☐ Neglect/Abuse ☐ Homelessness ☐ | |
| Is the Young Person subject to any current court orders or VRO’s? Yes ☐ No ☐ | | | | | |
| Can you please tell us a little more? | | | | | |
| Preferred day +/- time of session with a headspace worker:  Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐  Morning (8am-12pm) ☐Afternoon (12pm-4pm) ☐ Evening (4pm-6pm) ☐ | | | | | |
| **Involvement with other agencies/services** | | | | | |
| GP Name + Practice | |  | | | Is it ok to contact them? Yes ☐ No ☐ |
| Psychologist/Counsellor details | | |  | | Is it ok to contact them? Yes ☐ No ☐ |
| Other |  | | | | Is it ok to contact them? Yes ☐ No ☐ |
| Other |  | | | | Is it ok to contact them? Yes ☐ No ☐ |
| Previous mental health treatment/diagnosis: | | | | | |
| Relevant medical details, including medications (please attach existing Mental Health Treatment Plan, discharge summary, other): | | | | | |

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| --- | --- | --- | --- | --- | --- | --- |
| **Client Consent** | | | | | | |
| I have discussed headspace Pilbara services with the referring agency (where applicable) Yes ☐ No ☐ | | | | | | |
| I have agreed to accept headspace Pilbara services Yes ☐ No ☐ | | | | | | |
| I am aware that this referral is being made and a headspace worker will be phoning me or my parent/guardian to discuss Yes ☐ No ☐ | | | | | | |
| I understand I can withdraw from headspace Pilbara anytime Yes ☐ No ☐ | | | | | | |
| Young Person’s name | | |  | | Date |  |
| Young Person’s signature | | | |  | | |
| Consent Method | | | | Verbal ☐ Written ☐ | | |
| If the young person is **under 16 years of age**, authorisation should, **where possible,** be provided by a parent/guardian/carer. | | | | | | |
| Guardian name |  | | | | Date |  |
| Guardian signature | |  | | | | |

**queries / to chat with headspace regarding this referral : 1800 290 626**

**what happens next?**

1. Email this completed referral form to the below addresses; dependant on location of Young Person:

|  |
| --- |
| **headspace Karratha |** [**info@headspacekarratha.org.au**](mailto:info@headspacekarratha.org.au) |
| Karratha |
| **headspace Hedland |** [**info@headspacehedland.org.au**](mailto:info@headspacehedland.org.au) |
| Port Hedland + South Hedland |
| **headspace Pilbara |** [**info@headspacepilbara.org.au**](mailto:info@headspacepilbara.org.au) |
| Newman, Tom Price, Roebourne, Wickham, Onslow, Pannawonica, Paraburdoo, Marble Bar, Nullagine,  Yandeyarra + Western Desert Communities |

1. If we require further information from you, we will make contact
2. If we do not require information from you, please know that this referral will be triaged + assessed by our Clinical Team within 2 working days. We will contact the Young Person regarding the outcome of the referral and collaborate with any other person or service the Young Person has consented too moving forward. Generally, an initial appointment will be offered for the Young Person to meet with a headspace worker and engage in further assessment. If the referral is assessed to be outside our service model, we will contact yourself + the Young Person to suggest alternative support options.