Referral Date: _____

Details of young person

First name _____ Surname _____

Preferred name_____ Date of Birth_____

Gender ◯ male ◯ female ◯ trans male ◯ trans female ◯ gender neutral ◯ non-binary

Pronouns ◯ he him his ◯ she her hers ◯ them their theirs

Language other than English? Is an interpreter required?_____

Does this person identify as Aboriginal or Torres Strait Islander? ◯ Yes ◯ No

Address _____

Suburb/town _____Post Code _____

Email _____ Mobile _____

Medicare # _____Reference #_____ Expiry_____

Are there any alerts in regards to this referral that we should we aware of? (i.e. no parent contact, no letters home, etc)_____

_____

Other contact details

◯ emergency contact ◯ next of kin ◯ preferred contact person

Name _____ Mobile _____

Relationship to young person _____

Service delivery method

◯ face to face ◯ Telehealth ◯ phone ◯ appointments to be had at school

if at school, what school do you attend: _____

Details of referral

(Primary reason for referral)

◯ mental health ◯ drug and alcohol ◯ vocational ◯ GP services ◯ groups

◯ other _____

Details of referrer (person completing this document)

Name _____ Relationship to young person _____

Organisation (if applicable) _____

Phone _____ Email_____

Additonal referral details

Does the young person have a mental health care plan? ◯ Yes ◯ No

Does the young person have an NDIS plan? ◯ Yes ◯ No

Will you or another person from your service (if applicable) have continued involvement with this young person? ◯ Yes ◯ No

Has the young person agreed to this referral? ◯ Yes ◯ No

Is the young person currently involved in other support services?

If so, what are they (this includes GP, community service, mental health services, etc):

_____

_____

Presenting issues

- ○ Anxiety
- ○ School issues
- ○ Depression/Low Mood
- ○ Self-harm
- ○ Harm or threats to others
- ○ Stress
- ○ Suicidal thoughts
- ○ Suicidal behaviour
- ○ Difficulty sleeping
- ○ Drug abuse
- ○ Alcohol abuse
- ○ Pending legal matters
- ○ Children under 5
- ○ Pregnant
- ○ Family Problems
- ○ Physical Abuse
- ○ Relationship issues
- ○ Low self-esteem
- ○ Grief and loss
- ○ Emotional abuse
- ○ Hallucinations or delusions
- ○ Eating problems
- ○ History of hospitalisation
- ○ Anger
- ○ Crying
- ○ Financial difficulty
- ○ Domestic/family violence
- ○ Loss of appetite
- ○ Physical health
- ○ Sexual abuse
- ○ PTSD or trauma
- ○ Social problems
- ○ Learning disabilities
- ○ Body image
- ○ Bullying
- ○ Employment
- ○ Past or present contact with child safety
- ○ Previous incarceration or criminal history
- ○ I'm concerned about someone close to me

Risk

	NIL	Low	Medium	High	Comments
To self	○	○	○	○	
To others	○	○	○	○	
By others	○	○	○	○	

Please summarise the young person and what you hope headspace Horsham can achieve for them. Feel free to also add any relevant information not yet covered.

_____

_____

_____

_____

_____

_____

_____

Important information about your referral

headspace is a service for young people aged 12-25. We can only engage with young people who are happy and willing to engage and who have provided consent to the referral.

*headspace Horsham is **not** a crisis service. Please contact emergency services 000 if the young person is in crisis or at acute risk of harming themselves or others. In a mental health emergency please contact the Mental Health Service 24-hour call line 1300 661 323.*

To provide a complete referral email to info@headspacehorsham.org.au . We will endeavour to respond to referrals within 24-48 business hours, but if you have any queries please phone us on 5381 1543.

In agreeing to this referral, the young person is aware that they may withdraw from the referral or services at headspace Horsham at any time and we will use their contact details above to make future contact directly with them. Referrals will not be accepted without the consent of the young person.