Community Referral Form

headspace Onkaparinga

Referrer to complete form, fax to headspace Onkaparinga on (08) 8186 8699 and follow-up with a phone call on (08) 8186 8600 to ensure receipt of referral. All details must be completed or referral shall be returned.

Please note: Medium to High risk young people may not be appropriate for this service.

Emergency mental health services can be contacted by calling **13 14 65**

Date of Referral:	

Client details

Name:		**Gender:**	
DOB:		**Phone:**	
Address:			
Email address:			
Preferred mode of contact:	☐ **SMS** ☐ **Email** ☐ **Letter** ☐ **Mobile phone call**		
Who is the best person to contact regarding this referral?	☐Young person ☐Parent/guardian ☐Referrer		
Emergency Contact Name:		**Phone:**	
Does the client identify as an Aboriginal and/or Torres Strait Islander	☐ Yes ☐ No		
or of a Culturally and Linguistically Diverse background?	☐ Yes ☐ No		
Is an Interpreter required, if so which language?			
If the young person is aged under 16, is the parent or carer aware of the referral?	☐ Yes ☐ No		

Referrer details

Name:		**Phone:**		**Fax:**	
Organisation:					
Email address:					
Relationship to young person:					

Consent for Referral

I, ______________________________ (young person), agree to be referred to **headspace** Onkaparinga and give my permission for______________________________ *(Referrer's full name)* to provide/receive written and verbal information to/from **headspace** Onkaparinga for the purpose of facilitating this referral.

Client signature: ______________________________ *Date:* ____________________________

What has led to referring the young person to headspace? What are the current concerns? (you may want to attach further information)

Are there any other services involved in the young person's care?

Please indicate if any of the following are current areas the young person requires assistance with:

☐ Homeless or at risk of homelessness ☐ Pregnancy/young parent ☐ Mental health
☐ Family issues ☐ School issues ☐ Gender/Sexuality ☐ Trauma ☐ Physical/Sexual health
☐ Behavioural concerns ☐ Alcohol and drugs ☐ Work and Education options ☐ Body Image or Eating concerns

If you are concerned about this person's risk to themselves or others, please indicate how:

Tick each of the following options.

Is the young person currently having thoughts of suicide that you are aware of? ☐ Yes ☐ No

Does the young person have a current plan to end their life that you are aware of? ☐ Yes ☐ No

Does the young person have a history of suicide attempts or self-harm that you are aware of? ☐ Yes ☐ No

If you have answered YES to either of the above questions please contact us immediately on (08) 8186 8600 to discuss the referral suitability with our clinical team.

GP details

Does the client have an existing GP?		☐ Yes ☐ No *If yes, please provide details below.*			
GP Name:		**Phone:**		**Fax:**	
GP practice location/address:					

For clients under 16 years (signed consent required by parent/guardian):

Parent/Guardian name: ___________________________________

Parent/Guardian signature: ___________________________

Please fax completed referral form to **headspace** Onkaparinga on (08) 8186 8699.