Referral Form

Important Information About Your Referral

Once this form is complete please fax to headspace Cairns on 4041 6340

Referral criteria: 12-25 years old, early intervention. headspace Cairns often supports clients by referring them to other services where appropriate.

*Please note headspace Cairns is not an acute mental health/crisis service. If the client is high risk or in a crisis, please contact Cairns Child and Youth Mental Health Service (12-17yrs) on 4226 5280 or the Centralised Intake Service (18+yrs) on 1300 642 255

Young Person's Details

Full Name:	
Date of Birth:	
Gender:	
Address:	
Suburb:	Postcode:
Phone Number:	
Email Address:	
Preferred Person to Contact:	
Contact's number or email:	

Does the young person identify as: □ Aboriginal □ Torres Strait Islander □ Both

Does the young person require an interpreter

□ No □ Yes (please list language required): _____

Parent/Caregiver's Details (If the Young Person is under 16 years of age, we require a parent or caregiver to be documented on this form)

Full Name:	
Relationship to Young Person:	
Phone Number:	
Can we contact this person if the client is unavailable?	□ Yes □ No

Referrer's Details

Full Name:	Provider Number:
Organisation:	
Designation:	
Phone Number:	Fax Number:
Email:	

Primary Reason for Referral

□ Counselling
□ Physical and/or Sexual Health Needs
□ Alcohol and Other Drugs Support
□ Vocational/Employment

Presenting Issues and Relevant History

Please attach any relevant assessment notes, discharge summaries, and/or additional information

Current Support

Is the Young Person currently, or have they previously been, engaged with any of the following:

□ **General Practitioner** □ **Public Mental Health Service** □ **Drug and Alcohol Services**

□ **Private Practitioner** □ **Psychiatrist** □ **Employment Services**

□ **Homelessness Provider** □ **Child Protection Agency** □ **Juvenile Justice/Corrections**

Other Please specify:

What do you hope headspace Cairns can achieve for this client?

Authorisation of referral by client

- 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.
- I give permission for headspace Cairns to use my contact details above for future contact with me.
- I give permission for headspace Cairns staff to obtain further information relevant to this referral.

Signed: _____ Print Name: _____ Date: _____

If the young person is under 18 years of age, consent should be provided by a parent/guardian (if possible and/or appropriate):

Parent/Guardian Signed:_____ Print Name: _____ Date: _____

Doctors please note: If the client is eligible for a **Mental Health Treatment plan (2715 or 2717)**, attaching a copy of the plan to this referral will speed up their wait time for an appointment with an allocated clinician.