# Referral Form

## To be completed by services wishing to refer a young person to headspace Sale.

### Referral Criteria and Guidance

headspace Sale is a free, youth-friendly and confidential service available to young people aged 12-25 years, in the Sale and surrounding area. The services available at headspace Sale include:

|  |  |
| --- | --- |
| * Youth-Friendly GPs | * Counselling |
| * Alcohol & Drug Support | * Vocational support |
| * Psychologist services  (under a GP Mental Health Treatment Plan) | |

headspace Sale work with young people experiencing mild to moderate mental health issues such as stress, anxiety, depression or grief.

headspace Sale is not an acute mental health / crisis service. If you have any immediate concerns regarding the safety of a young person, please call:

* Kids Helpline: 1800 551 800
* Emergency Services: 000
* Lifeline: 13 11 14

Please return the completed referral form to:

|  |  |
| --- | --- |
| headspace Sale | Phone: 5184 5000 |
| PO Box 677  Bairnsdale, VIC 3875 | Email: referrals@headspacesale.org.au |
|  |  |

### Self-Referral

Young people can refer themselves to headspace Sale. Young people are encouraged to contact headspace Sale directly by either phoning, emailing or walk-in to the centre.

### Family and Friend Referral

Family, carers and friends can refer a young person to headspace Sale. Please contact headspace Sale directly by either phoning, emailing or walking in to the centre.

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| --- | --- |
| Young Person’s Details | |
| Has the young person consented to this referral?  Yes  No | |
| Name |  |
| Address |  |
| ­Date of Birth |  |
| Phone Number |  |
| Gender | Female  Male  Transgender  Other: |
| Cultural Identity | Aboriginal or Torres Strait Islander  CALD |

|  |  |
| --- | --- |
| Referring Service Details | |
| Date of Referral |  |
| Name |  |
| Address |  |
| Organisation |  |
| Position in Organisation |  |
| Phone Number |  |
| Email |  |

|  |  |
| --- | --- |
| Details of Suport People | |
| Young Person has consented to the following people to be contacted by headspace to support appointments.  Yes  No | |  |
|  |
| Name | **Relationship**  **to Young Person** |  |
| Phone Number | **Email** |  |
| Name | **Relationship**  **to Young Person** |  |
| Phone Number | **Email** |  |
| Name | **Relationship**  **to Young Person** |  |
| Phone Number | **Email** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Reason for Referral | | | |
| Please include any information which may be useful to assist with the referral (e.g. mental health, drug and alcohol, vocational / educational or physical health including past / current risk assessments). | | | |
| Does the young person:   * have an existing GP? | Yes | No | Unsure |
| If yes, please detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| * have an existing Mental Health Treatment Plan? | Yes | No | Unsure |
| * require an interpreter? | Yes | No | Unsure |

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| Risks to Worker Safety |
| Please include any known risks and current management strategies: |
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