

Please save this form to your computer before filling out and submitting.



Client details (these details will be used to contact the young person)

First Name _____ Surname _____

DOB _____ Age _____

Gender Male Female Other

Pronoun He Him His She Her Hers Them Their Theirs

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

Address _____

Suburb _____ Postcode _____

Home phone _____ Mobile _____

Email _____

Lives with _____ Relationship _____

Preferred contact person _____ Phone _____

Is the young person aware of the referral and wanting services from headspace Horsham?

Yes No

Reason for referral

Counselling services GP services Assessment of vocational needs

Alcohol and other drug Groups Other

Referrer details (person completing this document)

Contact name _____ Position/relationship _____

Organisation (if applicable) _____

Postal address _____ Postcode _____

Phone _____ Fax _____ Mobile _____

Email _____

Preferred delivery method of progress reports Fax Post

Authorisation of referral by person being referred

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 Horsham to use my contact details above for future contact with me.

I give permission for headspace Horsham staff to obtain further information relevant to this referral.

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1. Presenting Issues

- Anxiety
- Refusing school
- Depression
- Self harm
- Harm or threats to others
- Stress
- Suicidal
- Pending legal matters
- Difficulty sleeping
- Drug abuse
- Alcohol abuse
- Pain management issues
- Family problems
- Other _____
- Physical abuse
- Relationship issues
- Low self esteem
- Domestic violence
- Emotional abuse
- Hallucinations or delusions
- Eating problems
- History of hospitalisation
- Presentation to hospital
- ADHD or ADD
- Financial difficulty
- Loss of appetite
- Physical disability
- Sexual abuse
- PTSD or trauma history
- Social problems
- Aspergers or autism
- Body image
- Bullying others
- Crying
- Past or present contact with child safety
- Previous incarceration or criminal history

2. Risk

	Low	Medium	High	Comments
<input type="radio"/> To self	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/> To others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/> By others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

3. Is the young person currently linked in with any other services/health care workers?

4. What do you hope headspace Horsham can achieve for this client?

5. Summary of young person

Submit this form