## Young Person’s Details

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  |  |  | DOB: |   |
|  | First | Last |  |  |  |
| Address: |  |  |
|  | Street Address |  |
|  |  |  |  |
|  | City | State | Post Code |
| Is it okay for us to send **headspace** branded documents to this address?  | YES[ ]  | NO[ ]  |  |  |
| Phone: |  |  Email: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Gender: |  |  Preferred pronouns: |  |  Medicare No: |   |  Exp.  |  / |

|  |  |
| --- | --- |
| Next of Kin/Emergency Contact: |  |
|  | *Name Phone number* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does the young person require an interpreter? | YES[ ]  | NO[ ]  |  If yes, which language? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Does the young person identify as Aboriginal or Torres Strait Islander? | YES[ ]  | NO[ ]  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Does the young person have an existing GP? | YES[ ]  | NO[ ]  |  Does the young person have an existing MHTP? | YES[ ]  | NO[ ]  |

|  |  |
| --- | --- |
| Practice Name *(if applicable)*: |  |
| Doctor’s Name *(if applicable)*: |  |

## Referrer’s Details

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  |  |  |  Phone: |  |
|  | First | Last |  |  |  |
| Email: |  |

|  |  |
| --- | --- |
| Relationship to young person: |  |
|  |  *Organisation (if applicable)* |

## Important information about your referral

**headspace** is a service for young people aged 12-25.We can only engage with young people who have provided consent to the referral.
*If young person is unable to provide informed consent due to mental state (e.g. psychosis), please contact us.*

**headspace** Adelaide is not a crisis service and should you have any concerns, if the young person is in crisis, or if they are at an acute risk of harming themselves or others, please contact emergency services on **000**. In a mental health emergency, please contact Mental Health Triage on **13 14 65**

The receipt of the referral form does ***not*** indicate acceptance to **headspace** Adelaide. Suitability of the referral will be determined following assessment with the young person. Please contact us on 1800 063 267 to confirm receipt and discuss the outcome of your referral.

To provide a complete referral, please attach any relevant assessment notes, discharge summaries and/or additional information. We will endeavour to respond to referrals within 24-48 business hours, but if you have any queries pertaining to our referral, please phone us using the contact details above.

## Consent

|  |  |  |
| --- | --- | --- |
| Does the young person consent to this referral? | YES[ ]  | NO[ ]  |

## Reason for Referral

|  |
| --- |
| What are some of the current issues? *(please include info about duration, age of onset and pre-existing diagnoses):* |
|  |
| What has been the impact of these? *(e.g. relationships, school, work, home etc.):* |
|  |
| What are the young person’s goals and objectives? |
|  |
| Is there any family history of mental health conditions? |
|  |
| Is the young person currently supported by other health services? *(If so, please provide service details below)* Does the young person consent to **headspace** Adelaide exchanging information with these services to support this referral? *(If so, please provide contact details below)* |

|  |  |
| --- | --- |
| YES[ ]  |  NO [ ]  |
| YES[ ]  |  NO [ ]  |

 |
|  |

## Risk Factors *(referrer to complete)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Suicide | None[ ]  | Low[ ]  | Medium[ ]  | High[ ]  |  Other risk factors? *(e.g. homelessness, social withdrawal, medication compliance)* |
| Non-suicidal self-injury | None[ ]  | Low[ ]  | Medium[ ]  | High[ ]  |  |
| Harm to Others | None[ ]  | Low[ ]  | Medium[ ]  | High[ ]  |
| Vulnerability | None[ ]  | Low[ ]  | Medium[ ]  | High[ ]  |