## Referral to headspace Castle Hill

*Please ensure all sections are completed and legible.*
*Return via **email:** headspace.castlehill@flourishaustralia.org.au*
*Or **fax**: 02 8331 6055*

**headspace Referral Criteria :**

headspace is a voluntary service for young people aged between 12 and 25. **We can only connect with Young People if they have consented to the referral and are in this age group.**

The Young Person has consented to and provided permission for a referral? Yes ☐ No ☐

Is the Young Person aged 12 to 25? Yes ☐ No ☐

**headspace is not a crisis service.** We are unable to support severe mental health concerns or crisis referrals. **We suggest you please call the Mental Health Line on 1800 011 511** if the young person requires urgent mental health assistance.

**Please call headspace Castle Hill on 9393 9800 to ensure your referral has been received and to discuss anything further. If we are unavailable, we will respond to you within three working days.**

**Referrer Details:**

Name of Referrer: .....

Relationship to Young Person: ..... Organisation: .....

Contact Number: ..... Fax: .....

Service Address: .....

Email: .....

Do you wish to be part of our mailing list? Yes ☐ No ☐

**Parent/Guardian/Carer:** *

Name: .....

Relationship to young person: ..... Contact Number: .....

Interpreter Required? Yes ☐ No ☐

Do we have permission to speak with the person identified? Yes ☐ No ☐

**Young Person's Details:** *please note that if the Young person is aged 15 and under, we will require a parent or guardian to be documented on this form.

Name: .....

Date of Birth: ..... Age: ..... Pronouns: Gender: .....

Address: .....

Suburb: ..... Post code: .....

Contact Number 1: ..... 2. .....

Cultural Identity: ..... Language Spoken at home: .....

Preferred language: ..... Interpreter needed: Yes ☐ No ☐

Indigenous Identity: Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐

**Primary reason(s) for Referral:** This section **must** be completed and/or assessment notes attached

| | | | |
|---|---|---|---|
| ☐ | **Mental Health Support**<br>Brief 1-3 sessions | ☐ | **Physical Health Support** |
| ☐ | **Mental Health Support**<br>Focussed Psychological Interventions<br>(Mental Health Care Plan) | ☐ | **Vocation, Education, Training, Employment Support** |
| ☐ | **Alcohol and Other Drugs Support** | ☐ | **Groups Therapy** ☐ **Non-clinical Groups** |

**Presenting Issues:**

Does the Young Person have a Mental Health Care Plan (MHCP)? Yes ☐ No ☐

Can you support the Young Person to access a MHCP through a GP? Yes ☐ No ☐

Please provide the Young Person's Medicare card details:

Number: Reference Number: Expiry Date:

**If the Young Person has a pre-existing diagnosis, please provide details.** This may include details of diagnosis, details of diagnosing health professional, previous treatment, etc.

**Current presenting issues:**

**Other factors?** Is the Young Person currently undertaking or at risk of any of the following:

☒ Suicidal ☐ Harming self ☐ Harming others ☐ Extreme social withdrawal

☒ Homelessness ☐ Substance use ☐ School avoidance ☐ Other

Details:

Referrer Signature: Date:

**Thank you! If you have any concerns please phone Intake on 9393 9800.**