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| --- | --- | --- | --- | --- |
| **Referrer Details** | | | | |
| **Name** |  | | **Referral Date** |  |
| **Service** |  | | | |
| **Contact Number** |  | **Contact Email** |  | |

|  |  |
| --- | --- |
| **Young Person’s Details** | |
| **Name** |  |
| **Date of Birth** |  |
| **Address** |  |
| **Gender** | *(male / female / nonbinary / transgender / prefer not to say)* |
| **Preferred Pronouns** |  |
| *Completion of referral indicates consent for headspace to contact referrer and young person* | |
| **Contact Number** | Mobile:  Consent from young person to send SMS: Y / N Voicemail: Y / N |
| **Next of Kin** | Name:  Contact Number:  Consent to liaise with NOK: Y / N |
| **Parent/Guardian Consent for young people under 16 years** | Name / Contact Details (*if different to above):*  Y / N |

|  |  |  |  |
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| **Reason for Referral** | | | |
| Mental Health | Education Barriers | Conduct Difficulties | Sexuality / Gender |
| Drug and Alcohol | Employment | Police Involvement | Trauma |
| Physical Health | Risk of Homelessness | Family Conflict | Relationship Concerns |

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| **Additional Referral Information** |
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| **Risk** | |
| Is the young person currently suicidal? | **Y / N**  *If Yes, please refer to Child and Youth Mental Health or Adult Mental Health and/or phone headspace to discuss referral* |
| Are there additional risk areas identified for the young person? | **Y / N**  If Yes, provide additional detail: |
| Additional Referral/s Made |  |