ELIGIBITY CRITERIA:

* **Referral from Service Providers** **will require a copy of ALL relevant collateral information** *(including any assessments, discharge summaries & recovery documents)* **prior to the referral being triaged**
* All referrals will be triaged by the Clinical Team to assess eligibility and suitability for **headspace Ipswich**
* Outcome of referral will be provided directly to Service Provider via email, telephone and or fax
* General Practitioners are able to fax and or email a Mental Health Care Plan to **headspace** Ipswich instead of completing this referral form
* **headspace** Ipswich works **under Medicare Billing Model (MBS)**, this means young people are only **eligible for up to 10 Sessions** with Private Practitioners (Psychologists, Social Workers, Occupational Therapists)
* For further information on services available at **headspace** Ipswich please access our website
* Referrals from **Probation and Parole** require social history, information on convictions and pending legal matters including dates, prior to referral being triaged.Please note we are a voluntary service.

1. REFERRER (INDIVIDUAL COMPLETING THIS DOCUMENT)

Contact Name: Click here to enter text.

Position / Role: Click here to enter text.

Organisation: Click here to enter text.  
Postal Address: Click here to enter text. Postcode: Click here to enter text.

Phone: Click here to enter text. Mobile: Click here to enter text. Fax: Click here to enter text.

Email: Click here to enter text.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. YOUNG PERSON BEING REFERRED (THESE DETAILS WILL BE USED TO CONTACTED THE YOUNG PERSON/PARENT, GUARDIAN)

First Name: Click here to enter text. Surname: Click here to enter text.

Date of Birth: Click here to enter text. Age: Click here to enter text. Gender: M F Other: Click here to enter text.

Address: Click here to enter text.

Suburb: Click here to enter text. Postcode: Click here to enter text. State: Click here to enter text.

Home Ph: Click here to enter text. Mobile: Click here to enter text.

If Consent provided by young person, please provide details of their Parent/Guardian:   
Click here to enter text.

Mobile: Click here to enter text.

NOTE TO REFERRER

Please provide as much information as possible as it ensures the best quality of care, outcome and if required referral is afforded to the young person being referred.

If the young person is experiencing high levels of distress which may result in harm to themselves or others, please refer them directly to their local Emergency Department as headspace is not a Crisis Service or equipped to manage these types of emergencies.

3. REASON FOR REFERRAL

Mental Health Physical Health Vocational/Social Alcohol/Other Drugs Other (please specify): Click here to enter text.

4. INFORMATION ABOUT THE YOUNG PERSON

(If Applicable) Risk to self or others (Include self-harm/suicide attempts, violence, threats of violence, vulnerability).

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Type of Behavior | Reasons for Behavior | Outcome/Treatment Provided |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

(If Applicable) Other Agencies/Health Care Providers who are currently involved with the Young Persons Care: (e.g. Government, Non-Government, Psychiatrists, GP’s and Community Services)

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Organisation | Contact Person | Address | Phone |
|  |  |  |  |
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|  |  |  |  |

5. PRESENTING ISSUES

anxiety  pain management issues  adhd / add  refusing school

family problems  financial difficulty  depression  self-harm

physical abuse  loss of appetite  eating problems  suicidal

relationship issues  physical disability  drug abuse  crying

harm or threats to others  sexual abuse  stress  aspergers / autism

domestic violence  ptsd / trauma history  body image

emotional abuse  bullying others  pending legal matters

social problems at school  difficulty sleeping  intellectually impaired  
 presentation to ed or hospital  history of hospitalisation

past or present contact with child safety  hallucinations & delusions

other: Click here to enter text.

Do you have any final comments or relevant information?

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| --- | --- |
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6. Consent Of Young 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.  Please NOTE: Referrals will not be processed without signed consent. | |
| I give permission for **headspace** Ipswich to use my contact details above for future contact with me. | Yes  No |
| I give permission for the **staff** of **headspace** Ipswich to obtain relevant information from referrer pertaining to this referral | Yes  No |
| I give permission for **headspace** Ipswich to contact the referrer and advise once an appointment has been arranged. | Yes  No |

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name: Click here to enter text. Date: Click here to enter text.

*If under 18 years of age authorisation ideally should be provided by a parent/ guardian.*

Parent/Guardian Signed: Print Name: Click here to enter text. Relationship: Click here to enter text.

7. thank you for your referral

**Please return this form to headspace Ipswich**

Address: 26 East Street, Ipswich, QLD, 4305

Ph: 3280 7900

Email: Headspace.Ipswich@aftercare.com.au

Fax: 3280 7999

8. What Next?

* On receipt of a referral **headspace** Ipswich will contact the service provider to advise of outcome and then if applicable will contact the young person for a phone triage and or in addition to arrange a face to face appointment.
* All triage contact will be with a **headspace** Ipswich Intake and Assessment Officer.