

# headspace Referral Form

Referrer Details			
Referrer's name			Permission to contact referrer? Yes <input type="checkbox"/> No <input type="checkbox"/>
Relationship to YP			Is Young Person aware of referral? Yes <input type="checkbox"/> No <input type="checkbox"/>
Referrer's phone/email			Date of referral
Young Person Details			
Name			DOB
Address			
Mobile +/- Home			If we leave a message, can we say we are from headspace? Yes <input type="checkbox"/> No <input type="checkbox"/>
Gender identity	Female <input type="checkbox"/> Male <input type="checkbox"/> non-Binary <input type="checkbox"/> self-describe:		
Pronouns	She/Her <input type="checkbox"/> He/Him <input type="checkbox"/> They/Them <input type="checkbox"/> self-describe:		
Cultural Identity			
Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Aboriginal + Torres Strait Islander <input type="checkbox"/>			
non-Indigenous <input type="checkbox"/> self-describe:			
Country of birth			Place of birth
Which language are you most comfortable speaking in?			
Interpreter required? Yes <input type="checkbox"/> No <input type="checkbox"/>		Interpreter specifics	
Emergency Contact Details			
Name			
Address			
Mobile			Home
Relationship to Young Person			Can we contact this person about appointments? Yes <input type="checkbox"/> No <input type="checkbox"/>
Reason for referral			
Mental Health <input type="checkbox"/> Drugs + Alcohol <input type="checkbox"/> School / Work <input type="checkbox"/> General Physical +/- Sexual Health <input type="checkbox"/> Other <input type="checkbox"/>			
Can you please tell us a little more?			

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## Additional Information (if known)

Is the Young Person currently in crisis or at immediate risk to self or others? Yes  No

(headspace is not a crisis response service - please consider alternative referral if immediate support is required)

Risk assessment (please indicate)

Self-harm  Suicide Ideation  Suicide attempt

Violence/Aggression  Psychosis/Mania  Substance Use/Abuse

Neglect/Abuse  Homelessness

Is the Young Person subject to any current court orders or VRO's? Yes  No

Can you please tell us a little more?

Preferred day +/- time of session with a headspace worker:

Monday  Tuesday  Wednesday  Thursday  Friday  Saturday

Morning (8am-12pm)  Afternoon (12pm-4pm)  Evening (4pm-6pm)

## Involvement with other agencies/services

GP Name + Practice

Is it ok to contact them? Yes  No

Psychologist/Counsellor details

Is it ok to contact them? Yes  No

Other

Is it ok to contact them? Yes  No

Other

Is it ok to contact them? Yes  No

Previous mental health treatment/diagnosis:

Relevant medical details, including medications (please attach existing Mental Health Treatment Plan, discharge summary, other):

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Client Consent			
I have discussed headspace Pilbara services with the referring agency (where applicable) Yes <input type="checkbox"/> No <input type="checkbox"/>			
I have agreed to accept headspace Pilbara services Yes <input type="checkbox"/> No <input type="checkbox"/>			
I consent to the information provided on this form to be stored on our database Yes <input type="checkbox"/> No <input type="checkbox"/>			
I am aware that this referral is being made and a headspace worker will be phoning me or my parent/guardian to discuss Yes <input type="checkbox"/> No <input type="checkbox"/>			
I understand I can withdraw from headspace Pilbara anytime Yes <input type="checkbox"/> No <input type="checkbox"/>			
Young Person's name		Date	
Young Person's signature			
Consent Method	Verbal <input type="checkbox"/> Written <input type="checkbox"/>		
If the young person is <b>under 16 years of age</b> , authorisation should, <b>where possible</b> , be provided by a parent/guardian/carer.			
Guardian name		Date	
Guardian signature			

queries / to chat with headspace regarding this referral : 1800 290 626

## what happens next?

1. Email this completed referral form to the below addresses; dependant on location of Young Person:

<b>headspace Karratha   info@headspacekarratha.org.au</b>
Karratha
<b>headspace Hedland   info@headspacehedland.org.au</b>
Port Hedland + South Hedland
<b>headspace Pilbara   info@headspacepilbara.org.au</b>
Newman, Tom Price, Roebourne, Wickham, Onslow, Pannawonica, Paraburdoo, Marble Bar, Nullagine, Yandeyarra + Western Desert Communities

2. If we require further information from you, we will make contact
3. If we do not require information from you, please know that this referral will be triaged + assessed by our Clinical Team within 2 working days. We will contact the Young Person regarding the outcome of the referral and collaborate with any other person or service the Young Person has consented too moving forward. Generally, an initial appointment will be offered for the Young Person to meet with a headspace worker and engage in further assessment. If the referral is assessed to be outside our service model, we will contact yourself + the Young Person to suggest alternative support options.