

**Self-Referral and family/friend’s referral to headspace Lithgow**

**STOP** Professional referrer Please use ‘professional referral form’ Thanks….

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| **There are a few ways you can contact headspace Lithgow for an appointment. You are welcome to use the method that is most comfortable and convenient for you**  *Call us on the* ***Phone*** *at 6352 7600*  *Return this form via* ***email****:* hs.Lithgow@marathonhealth.com.au  *Come into the* ***centre:*** *23 Main St, Lithgow, 2790* | | | | | | |
| **Do you believe this young person is at risk of harm to themselves or other people?**  Yes  No  headspace is an early intervention and prevention service. If the young person is at risk of harm to themselves or to someone else, they are no suitable for headspace services. Please contact the mental health hotline on 1800 011 511 (24 hours) for appropriate services, take them to your nearest hospital, or call 000. | | | | | | |
| **Does the YP know about this referral?**  Yes  No  *If not, the referral cannot be accepted. Get in touch and we’ll talk you through some other options.*  **Is the YP between 12 and 25 years of age?**  Yes  No | | | | | | |
| **Young Person Details:** | | | | | | |
| **Young Persons preferred name:** | |  | | | | |
| **Age:** | |  | | **DoB:** | |  |
| **Gender:** | |  | | **Pronouns:** | |  |
| **Contact number:** | |  | | | | |
| Aboriginal  Torres Strait Islander  Both  Non-Indigenous | | | | | | |
| **Young Persons home Address:** | |  | | | | |
| **Referrer Details: (if a family member/carer/friend has completed this form)** | | | | | | |
| **Referrer’s Name:** |  | | **Relationship to Young person:** | |  | |
| **Referrers email address:** |  | | | | | |
| **Referrers contact number:** |  | | | | | |

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| **What do you hope headspace Lithgow can help you with?**  **What do you feel would be useful about coming to headspace, what are your goals?**  **How motivated are you to come?** |  |
| Have you **previously** seen another health practitioner? (e.g. Psychologist, Social Worker, Counsellor, Doctor) | Yes  No  If yes, Practitioner Name: |
| Are you **currently** engaged with, or have previously seen another health practitioner? (e.g. Psychologist, Social Worker, Counsellor, Doctor) | Yes  No  If yes, Practitioner Name: |
| **Is there a MHTP or referral from a GP?** | Yes  No |
| **Are you accessing services thought NDIS?** | Yes  No  **What services:** |
| **Do you currently access any other support organisations?** | Yes  No  **What organisations:** |
| **If under 16 are your parents / carers aware of this referral?** | Yes  No |
| **Is there a family member / worker you would like us to speak to?** | Yes  No  **Their Name:**  **Contact number:** |
| If you would like some support between now, head to **Spaces**: [www.headspace.org.au/eheadspace/spaces/personal/setup](http://www.headspace.org.au/eheadspace/spaces/personal/setup) it is an online place where you can connect with others, access eheadspace, and collect and manage resources to build your own personalised mental health toolkit. | |