**Intake Form**

Email to: headspaceliverpool@benevolent.org.au or

Fax referral to: 02 8568 7932

* We strongly recommend anyone referring a Young Person to also **call and speak to an intake worker** on 1800 026 517. Our opening hours are 8.30am to 5.00pm, Monday to Friday.
* Referrals are considered the week after we receive them. We’ll be in touch after that to offer an appointment or to discuss who might be in a better position to support you / the Young Person.
* **We are not an emergency service**. If you / the Young Person needs immediate assistance, please call the mental health care line (1800 011 511) or go to the nearest hospital emergency department.

**Date:**

**Who’s referring?** [ ]  Self [ ]  Service provider [ ]  Family/friend [ ]  Walk-in

**Does the YP know about this referral?** Yes [ ]

*If not, the referral cannot be accepted. Please call and we can support you to find other options.*

**Is the YP between 12 and 25 years of age?** Yes [ ]

**If under 16 years, are the parents/carers aware?** Yes [ ]

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Gender |  |
| Address |  |
| Who with? | [ ]  At home with family [ ] Living alone[ ]  Staying with friends [ ]  Homeless[ ]  Refuge [ ]  supported accommodation  |
| YP Phone Number |  |
| Email (optional) |  |
| Name of parent/guardian (optional) |  |  |

**Is YP at school, TAFE, university or working?** Yes [ ]  No [ ]

|  |  |
| --- | --- |
| Where?  | Year / Level?  |

**What cultural background does the YP identify as?**

**Does YP need an interpreter?** Yes [ ]  No [ ]

**If ‘Yes’, what language?**

**Is YP from a refugee background?** Yes [ ]  No [ ]

**Is YP of Aboriginal or Torres Strait Islander background?** Yes [ ]  No [ ]

|  |
| --- |
| 1. What’s lead to referring to headspace? What are the current concerns?
 |
| 1. Is the YP at risk of harming themselves or others? Are there any identifiable risk factors? (e.g. thoughts of suicide, self-harm, risk-taking behaviours, harming others)
 |
| 1. Anything else happening that might be affecting the YP? (e.g. family issues, exam stress, issues with friends or relationships)
 |
| 1. Anything from the past that might be affecting the YP now?
 |
| 1. Any previous mental health support / treatment, counselling, medication or diagnoses?
 |
| 1. What does the YP feel would be useful about coming to headspace? How motivated are they to come?
 |
| 1. Any other information that may be relevant? (e.g. family history of mental health issues, court involvement, intellectual disability, physical disability)
 |

**Are any of these issues for the YP at the moment?**

[ ]  Physical health [ ]  Sexual health [ ]  Body image [ ]  Alcohol or drugs

[ ]  Legal issues

**Referrer details (if appropriate)**

|  |  |
| --- | --- |
| Name  | Position / Organisation |
| Best contact number | Email |
| Fax  | *Address* |

**Who is the best person to contact about this referral?** [ ]  YP

 [ ]  Parent / Guardian

[ ]  Referrer

**Does YP have a GP?**  Yes [ ]  No [ ]

|  |  |
| --- | --- |
| GP Name | Medical Centre / Practice |

**Is there a current Mental Health Treatment Plan?** Yes [ ]  No [ ]

**Any other workers/services involved?**

|  |  |
| --- | --- |
| Name | Position / Organisation / Contact number |

|  |
| --- |
| (Office Use Only)**ALLOCATION FOLLOW-UP** |