Referral

Date: _____

Young person's details		
Name:	DOB:	Age:
Gender:	Phone:	Whose number is this:
Address:	Town:	Postcode:
□ Preferred person to contact to arrange an appointment		

Next of kin details		
Name:	Relationship:	Phone:
Address:	Town:	Postcode:
□ Preferred person to contact to arrange an appointment		

Referrer details		
Name:	Organisation:	Role:
Phone:	Email:	Fax:
Address:	Town:	Postcode:
□ Preferred person to contact to arrange an appointment		

Current treating GP		
Name:	Practice:	Phone:

Reason for referral

_____
_____
_____
_____
_____
_____

Current & previous service provision

Is the young person currently involved with or have they recently been involved with any of the following services:

Another headspace service	Currently □	Previously □	Never □	Unknown □
Child and adolescent mental health service (CAMHS)	Currently □	Previously □	Never □	Unknown □
Family and community services (FACS)	Currently □	Previously □	Never □	Unknown □
Adult mental health services	Currently □	Previously □	Never □	Unknown □
Psychologist	Currently □	Previously □	Never □	Unknown □
Psychiatrist	Currently □	Previously □	Never □	Unknown □
Paediatrician	Currently □	Previously □	Never □	Unknown □
Other mental health/support/counselling services	Currently □	Previously □	Never □	Unknown □

If yes is selected in any of the above, please provide details (please include any diagnosis and/or medications):

_____
_____
_____
_____
_____
_____

Risk assessment

Have there ever been any concerns or is there any current concerns for the following:

Suicidality	Currently □	Previously □	Never □
Self-harm	Currently □	Previously □	Never □
Homicidal ideation	Currently □	Previously □	Never □

If current or previous risk concerns, please provide details:

_____
_____
_____
_____
_____
_____

Referral

Date: _____

Current risk level		
Low (not urgent) □	Moderate (not urgent) □	High risk □
If young person is high risk or severely unwell they may not be best suited for headspace – please contact the mental health hotline on 1800 011 511 (24hrs) for appropriate services		

Consent		
Is the young person aware of the referral?	Yes □	No □
Is the young person willing to attend an appointment?	Yes □	No □
Is the young person's primary caregiver aware of the referral (where appropriate)?	Yes □	No □
Is the young person's primary caregiver willing to attend an appointment?	Yes □	No □

If no has been selected for any of the above, please provide details:

_____
_____
_____
_____
_____
_____

Office use

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

headspace Orange 264 Peisley Street, Orange NSW 2800 **Tel (02) 6369 9300 Fax (02) 6369 9399**
Email: hs.orange@marathonhealth.com.au ABN 86 154 318 975