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| *Please ensure all sections are completed and legible.*  *Return via* ***email:*** *headspace.Parramatta@Flourishaustralia.org.au*  *or* ***fax:*** *(02) 8331 6056* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **headspace Referral Criteria :** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| headspace is a voluntary service for young people aged between 12 and 25. **We can only connect with Young People if they have consented to the referral and are in this age group.** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The Young Person has consented to and provided permission for a referral? | | | | | | | | | | | | | | | | | | | | | | Yes | | | No | |
| Is the Young Person aged 12 to 25? | | | | | | | | | | | | | | | | | | | | | | Yes | | | No | |
| **headspace is not a crisis service.** We are unable to support severe mental health concerns or crisis referrals. **We suggest you please call the Mental Health Line on 1800 011 511** if the young person requires urgent mental health assistance.  **Please call headspace Parramatta on 1300 737 616 to ensure your referral has been received and to**  **discuss anything further. If we are unavailable, we will respond to you within three working days.** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referrer Details:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Referrer: | |  | | | | | | | | | | |  | | | | | | | | | | | | | |
| Relationship to Young Person: | | | |  | | | | | | | | | Organisation: | | | | |  | | | | | | | | |
| Contact Number: | |  | | | | | | | | | | | Fax: | | | |  | | | | | | | | | |
| Service Address: | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Email: | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you wish to be part of our mailing list? | | | | | | | Yes | | | No | | | | | | | | | | | | | | | | |
| **Parent/Guardian/Carer:** \* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Relationship to young person: | | | |  | | | | | | | | Contact Number: | | | | | | | | | | | |  | | |
| Interpreter Required? Yes  No  Do we have permission to speak with the person identified? Yes  No | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| **Young Person’s Details:** \*please note that if the Young person is aged 15 and under, we will require a parent or guardian to be documented on this form. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Birth: | | |  | | | | | Age: | | |  | | | | | Gender: | | | | |  | | | | | |
| Address: | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Suburb: | | |  | | | | | | | | | | | | | | | | | | Post code: | | | |  | |
| Contact Number 1: | | |  | | | | | | 2. | |  | | | | | | | | | | | | | | | |
| Cultural Identity: | | |  | | | | | | Language Spoken at home: | | | | | | | | | | | | | |  | | | |
| Preferred language: | | |  | | | | | | Interpreter needed: | | | | | | | | | | | | | | Yes  No | | | |
| Indigenous Identity: | | | Aboriginal | | | Torres Strait Islander | | | | | | | | | Both | | | | | | | | Neither | | | |
|  | | |  | |  |  | | | | | | | |  |  | | | |  | | | |  | | |  |

**Referral to headspace Parramatta**

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| **Primary reason(s) for Referral:** This section **must** be completed and/or assessment notes attached | | | | | | | | | | | | | |
|  | **Mental Health Support**  Brief 1-3 sessions | | | | | |  | **Physical Health Support** | | | | | |
|  | **Mental Health Support**  Focussed Psychological Interventions (MHCP/ATAPS) | | | | | |  | **Vocation, Education, Training, Employment Support** | | | | | |
|  | **Alcohol and Other Drugs Support** | | | | | |  | **Groups Therapy**     **Non-clinical Groups** | | | | | |
| **Presenting Issues:** | | | | | | | | | | | | | |
| Does the Young Person have a Mental Health Care Plan (MHCP)? Yes  No | | | | | | | | | | | | | |
| Can you support the Young Person to access a MHCP through a GP? Yes  No | | | | | | | | | | | | | |
| Please provide the Young Person’s Medicare card details where possible | | | | | | | | | | | | | |
| Number: | | |  | | | Reference Number: | | |  | | | Expiry Date: |  |
| **If the Young Person has a pre-existing diagnosis, please provide details.** This may include details of diagnosis, details of diagnosing health professional, previous treatment, etc. | | | | | | | | | | | | | |
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| **Current presenting issues:** | | | | | | | | | | | | | |
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| **Other factors?** Is the Young Person currently undertaking or at risk of any of the following: | | | | | | | | | | | | | |
| Suicidal | | | | | Harming self | | Harming others | | | Extreme social withdrawal | | | |
| Homelessness | | | | | Substance use | | School avoidance | | | Other | | | |
| Details: | |  | |  | | | | | | | | | |
| Referrer Signature: | | | | |  | | | | | | Date: | | |
| **Thank you! If you have any concerns please phone Intake on 1300 737 616.** | | | | | | | | | | | | | |