Referral Form

headspace Pilbara

Referrer's Name		Permission to contact referrer?	Yes	No
Relationship to YP				
Referrer's phone/email		Is Young Person aware of referral?	Yes	No
Date of referral:				

Young Person Details

Name:		DOB:	
Address:			

Mobile Phone:		Home Phone:		If we leave a message can we say we are from headspace?	Yes / No

Gender Identity:	Male	Female	Gender Diverse	Intersex	Indeterminate	Prefer to self-describe	Pronouns:
							She/Hers
							Him/His
Other:							They/Theirs

Cultural Identity

Aboriginal	Torres Strait Islander	Aboriginal & TSI	Non Indigenous	Prefer not to say	Other (More information)

Country of Birth:		Preferred Language:				
Place of Birth:		Interpreter required:	Yes		No	

Emergency Contact Details

Name:			
Address:			
Mobile Phone:		Home Phone:	
Relationship to Young Person:		Can we contact this person about appointments?	Yes / No

hPCLIN-039 June2020

Reason for Referral

Mental Health		Can you please tell us a little more?
Drugs & Alcohol		
School/Work		
General Health		
Other		

Additional Information (if known)

Is the Young Person currently in crisis or at immediate risk to self or others? (headspace Pilbara is not a crisis response service - please consider alternative referral if immediate support is required)	**Yes**	**No**

Risk Assessment: (please indicate)	**Self-harm**		**Suicide Ideation**		**Suicide Attempt**		**Violence Aggression**	
	Psychosis Mania		**Substance Use Abuse**		**Neglect Abuse**		**Homelessness**	
	Is the YP subject to any current court orders or VRO's?						Yes	No

Can you please tell us a little more?

Involvement with other agencies/services

GP Name and Practice:	**Is it OK to contact them?**	**Yes**	**No**
Psychologist/Counsellor Name and Organisation:	**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 diagnosis/treatment:	**Relevant medical details, including medications:** (please attach existing MHTP, discharge summary, other)

Client Consent		
I have discussed headspace Pilbara services with the referring agency where applicable)	**Yes** ☐	**No** ☐
I have agreed to accept headspace Pilbara services	**Yes** ☐	**No** ☐
I am aware that this referral is being made and a headspace worker will be phoning me or my parent/guardian to discuss:	**Yes** ☐	**No** ☐
I understand I can withdraw from headspace Pilbara anytime:	**Yes** ☐	**No** ☐
Young Person's Name:		
Young Person's Signature:	**Date:**	
If the young person is **under 16 years of age**, authorisation should **where possible** be provided by a parent/guardian/carer.		
Guardian Name:		
Guardian Signature:	**Date:**	