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| **For referrals from professionals/services external to headspace Shepparton:** Please ensure all sections are completed and legible prior to lodging referral.**For self-referrals from young people:** We look forward to meeting you soon! If you are a young person and looking for support, you have the option of completing this form, or simply calling, emailing or visiting us to say you’d like to chat. The same applies if you are a family member or friend of the young person seeking support. **Please check prior to referring:**headspaceShepparton is a voluntary service for young people between the ages of 12 and 25. headspace Shepparton can only engage with young people if they have consented to the referral. Young people under the age of 18 will require guardian consent, unless they are mature minors and assessed as this by an appropriate professional. If you’d like to speak with headspace about this further, please contact the headspace Shepparton office during business hours on (03) 5823 8800. headspaceShepparton is not a crisis service. We are unable to support severe mental health issues or crisis referrals. Please call Goulburn Valley Area Mental Health Services Triage on 1300 369 005 if you have concerns. In an emergency call 000. |
| **Date of referral:** |  | **Referrer name:** |  |
| **Consent** |
| Has the young person given consent to the referral?  | Yes [ ]  No [ ]  N/A [ ]  |
| Has the guardian given consent to the referral? (under 18s)  | Yes [ ]  No [ ]  N/A [ ]  |
| Is the young person aged 12-25? | Yes [ ]  No [ ]  N/A [ ]  |
| Is the young person a mature minor? (under 18s)  | Yes [ ]  No [ ]  N/A [ ]  |
| **Young Person’s Details** |
| Given name: |  | Preferred name: |  |
| Family name:  |  |
| Gender identity: |  |
| Date of Birth: |  |
| Address: |  |
| Suburb: |  | Postcode: |  |
| Phone: |  | alt. phone no: |  |
| Email: |  |
| Medicare number: |  |
| Medicare identifier: |  | Expiry: |  |
| Which contact/s would the young person prefer us to use? phone [ ]  email [ ]  contact via parent [ ]  |
| **Is the young person of Aboriginal and / or Torres Strait Islander descent?**Aboriginal [ ]  Torres Strait Islander [ ]  Aboriginal and Torres Strait Islander [ ]  No [ ] *If yes, do they identify as such?*Yes [ ]  No [ ]   |
| **Is the young person from a Culturally and Linguistically Diverse** **/ migrant / refugee background?** Yes[ ]  No [ ]  Country of birth: Language/s spoken at home: Interpreter required? Yes [ ]  No [ ]   |
| **Parent/Carer/Other Contact:** |
| Name:  |  |
| Relationship to young person:  |  |
| Phone: |  |
| Address:  |  |
| **Referrer Details** |
| Name of Referrer:  |  |
| Relationship to young person: |  |
| Service/organisation *(if applicable)*:  |  |
| Address: |  |
| Phone: |  | Mobile: |  |
| Fax: |  | Email: |  |
| **Does the young person see any other services at the moment?** If yes, please tick appropriate box/boxes: |
| Drug and Alcohol [ ]  School Counsellor [ ]  Other Counsellor [ ]  Youth Justice [ ] Community Services [ ]  Adult Mental Health/GVAMHS [ ] CAMHS/CYMHS (Child & Adolescent/Youth Mental Health Services)[ ]  Other *(specify):* |
| **GP Details** |
| Clinic: |  | Doctor name: |  |
| Will the service continue working with the young person? Yes [ ]  No [ ]  |

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| **Reasons for Referral** |
| Mental health [ ]  Physical/Sexual Health [ ]  Drug & Alcohol [ ]  Work & Study [ ]  Diversity [ ]  Other [ ]   |
| Main issues:  |
| Pre-existing diagnoses/relevant past history:  |
| What are your expectations of headspace Shepparton?  |
| Other comments:  |
| **Referral Contact** |
| Who should we contact first in regard to this referral? [ ]  Referrer [ ]  Parent/carer [ ]  Young person |
| If we are unable to contact the young person, can we contact the parent/carer/other contact? Yes [ ]  No [ ]  |
|  |
| **Check before submitting** |
| Young person is aged between 12 and 25  | [ ]  |
| Young person consents to the referral | [ ]  |
| Guardian consents to the referral (under 18) | [ ]  |
| Young person is mature minor (under 18) | [ ]  |
| Young person/parent/referral contact is aware that they will be contacted by headspace via phone call from a private number.  | [ ]  |
| Date of referral |  |
| Referral completed by: |  |
| Signature |  |

**Please Note:** Referrals will be responded to within 3 working days. If you have not received

confirmation of receipt of this referral, please call us on 03 5823 8800.

headspace Shepparton

129 High St, Shepparton 3630

T: 03 5823 8800 F: 03 5821 8678 E: intake.headspace@gvhealth.org.au [www.headspace.org.au/shepparton](http://www.headspace.org.au/shepparton)