headspace Upper Coomera

Referral Form

### *Please return completed form to*:

**Email:** reception@headspaceuc.org.au

**Phone:** 07 5600 1999 **Fax:** 07 3568 8300

All enquiries are welcome

**PRIMARY REASON (S) FOR REFERRAL**

Mental Health Alcohol/Drug Use Physical Vocational Other

**PERSON BEING REFERRED (THESE DETAILS WILL BE USED TO CONTACT THE YOUNG PERSON / PARENT, GUARDIAN)**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name:  |  | Last Name: |  |
| Date of Birth: |  | Gender: |  | Pronouns: |  |
| PrimaryMobileContact & Name: |  | Secondary Phone Contact & Name: |  |
| Email: |  |
| Address: |  |
| Parent/ Guardian Name and Contact Number: (if consent given by young person) |

**AUTHORISATION OF REFERRAL BY PERSON BEING REFERRED**

Please NOTE: Referrals will not be processed without signed consent.

I am aware that this referral is being made. I understand that I can withdraw from this referral or from the referred service at any time.

I give permission for **headspace** Upper Coomera to use my contact details above for future contact with me.

Yes No

I give permission for the **staff** of **headspace** Upper Coomera to obtain relevant information from government and non-government agencies, from doctors and other health professionals specifically relevant to my care whilst being a client of **headspace** Upper Coomera.

|  |  |
| --- | --- |
| Signed |  |
| Print Name: |  | Date: |  |

If under 18 years of age, authorisation ideally would be provided by a parent/ guardian.

If under 16 years of age consent is required by a parent/ guardian

|  |  |
| --- | --- |
| Signed |  |
| Parent/Guardian Name: |  |
| Relationship: |  | Date: |  |

**REFERRER (INDIVIDUAL COMPLETING THIS DOCUMENT)**

|  |  |
| --- | --- |
| Contact Name |  |
| Position / Relationship: |  |
| Organisation (if applicable): |  |
| Phone: |  | Mobile: |  |
| Email: |  | Fax: |  |
| Signed: |  |

PRESENTING ISSUES

 ADHD / ADD HARM OR THREATS TO OTHERS

 ALCOHOL ABUSE HISTORY OF HOSPITALISATION

 ANXIETY INTELLECTUAL DISABILITY

 ASPERGERS / AUTISM LOSS OF APPETITE

 BODY IMAGE LOW SELF ESTEEM

 BULLYING OTHERS PENDING LEGAL MATTERS

 CRYING PAIN MANAGEMENT ISSUES

 DEPRESSION PHYSICAL ABUSE

 DIFFICULTY SLEEPING PHYSICAL DISABILITY

 DOCS PTSD

 DOMESTIC VIOLENCE REFUSING SCHOOL

 DRUG USE RELATIONSHIP ISSUES

 EATING PROBLEMS SEXUAL ABUSE

 EMOTIONAL ABUSE SELF HARM

 FAMILY PROBLEMS SOCIAL PROBLEMS AT SCHOOL

 FINANCIAL DIFFICULTY STRESS

 FUNCTIONAL DECLINE SUICIDAL

­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­ HALLUCINATIONS AND DELUSIONS TRAUMA HISTORY

 OTHER (PLEASE DESCRIBE)

|  |
| --- |
| CAN YOU TELL US MORE? (ABOUT THE BOXES TICKED ABOVE)  |
|  |

**RISK TO SELF OR OTHERS (INCLUDE SELF HARM, SUICIDE ATTEMPTS, VIOLENCE, THREATS OF VIOLENCE)**

Please note:headspace **is not a Crisis Service,** if the young person is experiencing high levels of distress which may result in harm to themselves or others, please refer them directly to their local Emergency Department.

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** |  | **Type of Behaviour:** |  |
| **Reason for Behaviour:** |  |
| **Outcome/ Treatment: Provided** |  |

**OTHER AGENCIES/HEALTH CARE PROVIDERS CURRENTLY INVOLVED WITHIN THE YOUNG PERSON’S CARE**

**(IE. GOVERNMENT, NON-GOVERNMENT, GP’S, PSYCHIATRISTS AND COMMUNITY SERVICES)**

|  |  |
| --- | --- |
| Contact Person: |  |
| Organisation: |  | Phone: |  |
| Email: |  |

|  |  |
| --- | --- |
| Contact Person: |  |
| Organisation: |  | Phone: |  |
| Email: |  |

**ELIGIBILITY CRITERIA:**

* Referrals from QLD Health and other service providers require a copy of ALL relevant collateral information (including assessment, discharge summaries & recovery documents) prior to referral being processed.
* Referrals from Probation and Parole require information on convictions and pending legal matters including dates, along with AOD information prior to referral being processed.
* General Practitioners can fax or email a Mental Health Care Plan to headspace Upper Coomera instead of completing this referral.

Please **fax** or **email** referral form to: **(07) 3568 8300** or **reception@headspaceuc.org.au**

For more information please call: **(07) 5600 1999**