# Service Provider Referral Form

Once complete please send this form to:
Fax: (02) 8021 7410 or
Email: chatswoodintake@newhorizons.org.au

**Please note that headspace is not a Crisis or Emergency Service. In the event of a Mental Health Crisis, please call the NSW Mental Health Line on 1800 011 511.**

**In an emergency, call 000 or go to a hospital emergency department.**

headspace Chatswood

**Date of Referral:**

## Consent

At headspace Chatswood, it is our standard practice to obtain a parent or guardian's consent for young people under 16 years of age.

Has the young person consented to the referral: ☐ Yes ☐ No (If no, the referral cannot be accepted)

If the young young person is under 16 years of age, are the parents/carers aware of this referral?
☐ Yes ☐ No (If no, the referral cannot be accepted)

## Young person's details

Surname: First name:

Preferred name: Gender: Age: Date of birth:

Address:

Suburb: Postcode:

Home Phone: Can we leave a message? Mobile: Can we leave a message?

Is the young person of Aboriginal and/or Torres Strait Islander origin? Cultural Background:

Educational Status (highest level obtained) School/Institution:

Occupation: Employment Status:

Medicare card number (if known): Expiry Date:

Is the young person on any Centrelink payments? (If so please list:)

## Referrer Details

Name: Relationship to young person:

Organisation:

Address: Suburb: Postcode:

Email: Contact number:

## GP Details (if known)

Name: Provider Number:

Practice Name/ Address:

Mental Health Treatment Plan created? Date of plan:

## Next of Kin Details

Name: Relationship to young person:

Address: Phone:

Can we contact next of kin? ☐ Yes ☐ No, unless in emergency ☐ If young person is not contactable

## Presenting Problem

**What is the main concern for this young person?**

Please include comment on symptoms, current functioning, mental and physical health concerns, school attendance refusal, family issues, drug/alcohol and vocational issues.

**Is the young person at risk of harming themselves or others?**

Detail: (Aggressive behaviour, Suicide/self harm, Plan, Access to Means, History of Attempts, Lethality, NSSI)

**Has the young person ever received prior mental health care or are they currently receiving treatment?**

(by whom/dates/medications/ please include any hospital admissions):

If there is a discharge summary or other relevant documentation, please attach more information and detail as necessary.

**We will review this referral at our intake meeting and will respond regarding the outcome of referral as soon as we can.**

Office Use Only

Intake Clinician:

Assessment Date:

Referral Method:

MasterCare Team:

Young person entered into HAPI?