Referral Guidelines

**About headspace Emerald:**

Opening hours:

Monday: 10:00AM – 5:00PM

Tuesday: 10:00AM – 5:00PM

Wednesday: 10:00AM – 7:00PM

Thursday: 10:00AM – 7:00PM

Friday: 09:00AM – 3:00PM

headspace Emerald is a free or low cost, youth friendly and confidential service, providing brief and early intervention services for young people aged 12-25 years experiencing low-moderate mental health concerns.

headspace Emerald provides support with-in these four core streams:

1. Mental health and wellbeing
2. Physical and sexual health
3. Alcohol and other drugs
4. Vocational and educational

**Eligibility criteria:**

headspace Emerald is an early intervention service for young people aged 12-25 with mild to moderate mental health concerns.

* Referrals from QLD Health require a copy of ALL relevant collateral information (including assessment, discharge summaries, & recovery documents) prior to the referral being processed.
* Referrals from Child Safety require a copy of ALL relevant collateral information (including assessment, care arrangements, & court orders) prior to the referral being processed.
* Referrals from Youth Justice or Probation and Parole require a copy of ALL relevant collateral information (particularly regarding risks), along with AOD (Alcohol and Other Drugs) information prior to referral being processed.

**How Does Headspace Emerald Achieve This?**

* identifying the young person’s holistic wellbeing concerns and goals through a comprehensive assessment
* providing evidence based clinical brief interventions
* supporting the young person with appropriate mental health and psycho-social supports in the community and online
* delivering early intervention-based group programs and prevention tools via mental health literacy sessions, workshops, or presentations

**Please Note:**

headspace Emerald is not an acute mental health/crisis service. If you have any immediate concerns regarding the safety/wellbeing of a young person, please call: 1300 MH CALL (1300 642255), Lifeline on 13 11 14; or Kids Helpline on 1800 55 1800. In an emergency, contact 000 immediately.

**How To Refer:**

**Self-referral**

Young People are encouraged to make contact with headspace Emerald directly. We understand this can be a new experience, so support from a referrer during the initial meeting would be appreciated, if required.

**By phone/email**

Call 1800 950 722 or email intake.headspaceemerald@anglicarecq.org.au and a headspace team member will call you back to make an appointment within 1 – 2 working days.

**Drop in**

Young people can call into headspace Emerald, 65 Hospital Road, between business hours, Monday – Friday. Staff will endeavor to see the young person the same day or the next available appointment will be offered.

**Professional referral**

GP’s, Allied Health Professionals, community-based agencies, and educational institutions can all refer young people to headspace Emerald using the Referral Form attached. General Practitioners should include a mental health care plan (if appropriate) for the young person and attach this to the headspace Emerald referral form.

**Family referral**

Families, carers, or friends can refer a young person to headspace Emerald. The young person needs to be aware of and consent to the referral and be willing to meet with a member from the headspace Emerald team. Once receipt of referral has been confirmed, a worker will contact the young person within one to two working days to make an appointment. Families, parents, or carers who have a young person engaged with headspace Emerald can also access our centre to discuss service provision.

Please Note: Referrals will be responded to within 2 working days. If you have not received confirmation of receipt of this referral, please call us on 1800 950 722 or 07 4897 2300.

**headspace Emerald**

65 Hospital Road, Emerald, Qld, 4720

P: 1800 950 722

T: 07 4897 2300

Please send referrals to our intake email: intake.headspaceemerald@anglicarecq.org.au

For all other inquiries please email: headspace.emerald@anglicarecq.org.au

Referral Form

**REFERRER DETAILS**

|  |  |
| --- | --- |
| Referral Date |  |
| Organisation Name |  |
| Program Name |  |
| Name  |  |
| Position  |  |
| Address |  |
| Preferred Contact *(Provide details for at least one contact)* | Telephone: |  |
| Email: |  |

**PARTICIPANT IDENTIFICATION / CONTACT INFORMATION**

|  |  |
| --- | --- |
| Name |  |
| Referral Type (if applicable)  | [ ]  Self | [ ]  Walk-in | [ ]  Phone | [ ]  Other | [ ]  N/A |
| Current living situation | [ ]  Accommodated     [ ]  Homeless  |
| Home Address  |  |
| Mailing Address | Same as above:[ ]  Yes[ ]  No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Consent for Referral | [ ]  Yes    [ ]  No |
| Contact Number |  |
| Email Address |  |
| Date of Birth *(dd/mm/yyyy)**(Age for referral: 12yrs – 25yrs)* |  | Age *(years)* |  |
| Medicare Card |  | IRN: |  |
| Gender | [ ]  Male | [ ]  Female | [ ]  Other: |
| Preferred Pronouns | [ ]  He/Him  | [ ]  She/Her | [ ]  They/Them  | [ ]  Other: \_\_\_\_\_\_\_\_  |
| Caregiver Contact | Name: |  |
| Relationship: |  |
| Telephone: |  |
| Consent to Contact Caregiver  | Consent for emergencies: [ ]  Yes    [ ]  NoConsent relating to service delivery: [ ]  Yes    [ ]  No (Appointment reminders etc)  |
| Primary Nominated Professional?*(This person will be informed of the participant’s entry into & exit from the service*) | Name: |  |
| Telephone: |  |
| Email: |  |

**ELIGIBILITY CRITERIA**

|  |  |  |
| --- | --- | --- |
| Criteria *(Please tick one)****Reason for Referral*** | [ ]  mental health | [ ]  general health *(including sexual health)* |
| [ ]  alcohol and drug | [ ]  work and study |
| Main Issues: |  |
| Pre-existing diagnoses/relevant past history:  |  |
| Other comments in regard to referral |  |

**YOUNG PERSON RISK FACTORS**

|  |  |  |
| --- | --- | --- |
| Does the client have a current risk assessment? | [ ]  Yes *(Required to be attached)*  | [ ]  No |

**MEDICATION**

|  |  |
| --- | --- |
| Medication? If yes, what? |  |

**CARER / SUPPORT PERSON INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Carer, family member or other person that may need support? | [ ]  Yes | [ ]  No | [ ]  Not stated |
| If yes, what is the name of this person? |  |
| Best contact number for this person? |  |

PRESENTING ISSUES

|  |  |  |
| --- | --- | --- |
| [ ]  Anxiety | [ ]  Pain Management Issues | [ ]  ADHD/ADD |
| [ ]  Refusing School | [ ]  Family Problems | [ ]  Financial Difficulty |
| [ ]  Depression | [ ]  Physical Abuse | [ ]  Loss of Appetite |
| [ ]  Self-Harm | [ ]  Relationship Issues | [ ]  Physical disability |
| [ ]  Harm or threats to others | [ ]  Sexual Abuse | [ ]  Intellectually Impaired |
| [ ]  Stress | [ ]  Domestic Violence | [ ]  PTSD/Trauma History |
| [ ]  Suicidal | [ ]  Emotional Abuse | [ ]  School Social Problems |
| [ ]  Crying | [ ]  Hallucinations and delusions | [ ]  Asperger’s/Autism |
| [ ]  Difficulty sleeping  | [ ]  Eating Problems | [ ]  History of hospitalisation |
| [ ]  Drug Abuse | [ ]  Body Image | [ ]  Alcohol Abuse |
| [ ]  Presentation to ED or Hospital | [ ]  Bullying Others | [ ]  Low Self Esteem |
| [ ]  Past or present contact with CS | [ ]  Pending Legal Matters | [ ]  Functional decline |
| [ ]  Other: |

**ADDITIONAL PARTICIPANT INFORMATION (Minimum Data Set)**

|  |  |  |  |
| --- | --- | --- | --- |
| Relationship Status  | [ ]  Never married | [ ]  Married/De facto | [ ]  Separated  |
| [ ]  Divorced | [ ]  Not Stated |  |
| Dependents under 18 years  | [ ]  Yes | [ ]  No | [ ]  Not stated |
| Indigenous Status  | [ ]  Aboriginal but not Torres Strait Island origin |
| [ ]  Torres Strait Islander but not Aboriginal origin |
| [ ]  Both Aboriginal and Torres Strait Islander origin |
| [ ]  Neither Aboriginal nor Torres Strait Islander origin |
| [ ]  Not stated/inadequately described |
| Country of Birth |  |
| Main Language spoken at home |  |
| Sexual Orientation | [ ]  Straight or heterosexual | [ ]  Lesbian, gay or Homosexual |
| [ ]  Bisexual or pansexual | [ ]  Questioning |
| [ ]  Asexual | [ ]  Queer |
| [ ]  Other | [ ]  Not stated |
| Does the participant have a transgender history? | [ ]  Yes | [ ]  No | [ ]  Not stated |
| Current living situation  | [ ]  Currently accommodated | [ ]  Currently homeless |
| [ ]  Currently accommodated but at risk of homelessness  |
| Employment/studying status: | [ ]  Employed | [ ]  Unemployed | [ ]  Currently looking |
| [ ]  Student | [ ]  Unknown |  |
| [ ]  Other: |
| Do they have a Health Care Card:  | If yes Details:  |
| Do they have a National Disability Insurance Scheme (NDIS) plan? | If yes Details: |

**ADDITIONAL INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Your preference for introduction of this participant? | [ ]  Telephone | [ ]  Online *(Videoconference)* | [ ]  Face to Face |
| Preferred date, time, and contact number? |  |