Please note that headspaceGreensborough is **not a crisis service**. Crisis care can be accessed via Austin CYMHS (12-18yo) 03 9496 3620, Eastern CYMHS (12-25yo) 1300 721 927 or North East Mental Health Triage (all ages) 1300 859 789

headspace Greensborough offers early intervention support for young people aged 12-25 years experiencing mild to moderate mental health difficulties.

Date:

|  |
| --- |
|  **Young Person’s Details** Young person is aware about and agrees to referral: ☐ Yes |
| Title: | Name: |
| Gender identity: | DOB: |
| Address: |
| Phone: | Email:  |
| Preferred mode of contact: ☐ SMS ☐ Phone call ☐ Email ☐ Letter |

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| --- |
|  Young Person’s Language and Culture |
| Tick any that apply:  | ☐ Aboriginal ☐ Torres Strait Islander ☐ Culturally and Linguistically Diverse |
| Does the young person require an interpreter? ☐ No ☐ Yes, please state what language (including Auslan): |

|  |
| --- |
| Referral Information |
| Does the young person have a Mental Health Plan? ☐ No ☐ Yes |
| Other organisations/supports in place (i.e. GP, school wellbeing, family services – please include role and contact information) |
| Risk issues (i.e. suicidal ideation, self-harm, protective issues) |

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| **Emergency Contact** |
| Name: | Phone: |  |
| Relationship to young person: |  |  |

|  |
| --- |
| **Referrer Details** |
| Name: | Role: |
| Phone: | Agency: |
| Fax: | Email:  |

|  |
| --- |
| **Consent** |
| I, [carer’s name if young person under 16, young person’s name if 16 or over], give consent for this referral to be made and give permission for \_\_\_\_\_ [referrer name] to exchange information with headspaceGreensborough for the purpose of this referral.Young person/carer signature: Date: OR Tick if verbal consent was obtained ☐ |

Please send through any relevant documentation with your referral (i.e. MHCP, assessments or discharge plan) via email to: headspacegreensborough@mindaustralia.org.au or fax: 03 9435 8621