Please save this form to your computer before filling out and submitting.

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Client details (these details will be used to contact the young person)

First Name _____ Surname _____

DOB _____ Age _____

Gender ◯ Male ◯ Female ◯ Other

Pronoun ◯ He Him His ◯ She Her Hers ◯ Them Their Theirs

Does this person identify as Aboriginal or Torres Strait Islander ◯ Yes ◯ No

Language other than English _____

Address _____

Suburb _____ Postcode _____

Mobile _____ Email _____

Medicare card number _____

Private health fund _____ Number _____

Preferred contact person _____ Relationship _____

Preferred contact phone _____

Service delivery method

◯ Face-to-face ◯ Telehealth

Reason for referral

◯ Counselling services ◯ GP services ◯ Assessment of vocational needs

◯ Alcohol and other drug ◯ Groups ◯ Other

Referrer details (person completing this document)

Contact name _____ Position/relationship _____

Organisation (if applicable) _____

Postal address _____ Postcode _____

Phone _____ Fax _____ Mobile _____

Email _____

Preferred delivery method of progress reports ◯ Fax ◯ Post

Authorisation of referral by person being referred

◯ 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 Horsham to use my contact details above for future contact with me.

◯ I give permission for headspace Horsham staff to obtain further information relevant to this referral.

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1. Presenting Issues

- ◯ Anxiety
- ◯ Refusing school
- ◯ Depression
- ◯ Self harm
- ◯ Harm or threats to others
- ◯ Stress
- ◯ Suicidal
- ◯ Pending legal matters
- ◯ Difficulty sleeping
- ◯ Drug abuse
- ◯ Alcohol abuse
- ◯ Pain management issues
- ◯ Family problems
- ◯ Other _____
- ◯ Physical abuse
- ◯ Relationship issues
- ◯ Low self esteem
- ◯ Domestic violence
- ◯ Emotional abuse
- ◯ Hallucinations or delusions
- ◯ Eating problems
- ◯ History of hospitalisation
- ◯ Presentation to hospital
- ◯ ADHD or ADD
- ◯ Financial difficulty
- ◯ Loss of appetite
- ◯ Physical disability
- ◯ Sexual abuse
- ◯ PTSD or trauma history
- ◯ Social problems
- ◯ Aspergers or autism
- ◯ Body image
- ◯ Bullying others
- ◯ Crying
- ◯ Past or present contact with child safety
- ◯ Previous incarceration or criminal history

2. Risk

	Low	Medium	High	Comments
◯ To self	◯	◯	◯	
◯ To others	◯	◯	◯	
◯ By others	◯	◯	◯	

3. Is the young person currently linked in with any other services/health care workers?

4. What do you hope headspace Horsham can achieve for this client?

5. Summary of young person

Submit this form