**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Young Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_\_**

**Gender Identity:** \_\_\_\_\_\_\_\_\_\_\_\_ Sex assigned at birth: \_\_\_\_\_\_\_\_\_\_\_ Pronoun: \_\_\_\_\_\_\_\_\_\_\_\_\_ **Age: ­­­­­­­­­­­­­­­­\_\_\_**

**Do they identify as:** Aboriginal  Torres Strait Islander  Both  Other  \_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:­­­­­­­­­­­­­­­­ ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Post Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact numbers: Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is the young person currently in crisis or at risk to self or others? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (headspace is not a crisis response service – consider an alternative referral)

**Consent - Has the young person agreed to this referral?** (headspace requires young person’s consent) Yes

**Contact preferences and availability:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please be specific. Can we call while at school or work? Do they have a day or time that is best for contact)

**Consent to contact young person via:**

**Text:** Yes  No  **Voicemail:** Yes  No  **Home Phone:** Yes  No   
**Mail:** Yes  No  **Email:** Yes  No ­­­­­­­­­­­­­ **Txt reminders to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is Parent/Guardian/Carer aware that you are accessing support from headspace Rockingham?**

(If under the age of 16 years parent/guardian consent may be required) Yes No

**Consent for Parent/Guardian/Carer to schedule or cancel appointments?** Yes No

**Emergency Contact** (Over 18 years of age)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicare Information**

Medicare No: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ Reference No: \_\_ Expiry Date: \_\_\_ / \_\_\_\_\_\_\_\_  On file

NB: If a young person is 15 or over, they can apply for their own Medicare card.

The application form can be found on http://www.humanservices.gov.au/spw/customer/forms/resources/3170-1308en.pdf

**Referral Source:** Young Person  Family/Friend  Agency  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Details of Referrer Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Email:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agency/Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Contact Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE FORWARD ANY AVAILABLE DOCUMENTATION**

Attached: Referral Letter  Discharge Summary  Mental Health Plan  Notes  Assessment

Has the YP received assistance from other mental health services prior to this referral? Yes  No

Is the YP currently receiving assistance from another mental health service? Yes  No

Details of organisation, contact person and hone details, support received and consent to contact

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you referred this young person to any other service? Yes  No  N/A  (please provide details)

**Presenting concerns (INCLUDE DURATION)**

(NB: if young person identifies physical/sexual health concerns, only the 1st page needs to be completed).

Mental Health  Physical Health  Sexual Health  Alcohol and Drugs

Situational  Vocational/Education  Social Support  Family Support

Eating  Home/Environment  Friendships  Relationships/Sexuality

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does the Young Person have a GP and is it OK to contact them**? Yes  No

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Medical Centre:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Contact No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MH diagnosis (if relevant): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current MHTP?** Yes  No  Date completed by GP: \_\_/\_\_/\_\_\_\_

**Current Medication?** Yes  No  Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Risk Assessment** (NB: Include harm to self/others, suicide ideation/attempts, neglect, abuse, homeless, etc.):

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Risk** | **Identified Trigger** | **Outcome/ Treatment Provided** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

* All referrals will be considered, however if the young person is better suited to an alternative support option **headspace** Rockingham will attempt to notify the referring agency with the recommendations.
* On receipt of this form, **headspace** Rockingham will contact the young person to discuss support options available.
* With consent from the young person, **headspace** Rockingham will advise the referring agency of the young person making an initial appointment.
* If **headspace** Rockingham is unable to contact the young person, they will notify the referring agency.
* If you need further information, please contact **headspace** Rockingham on (08) 6595 8888.
* Please forward completed this form and all supporting documentation to **headspace** Rockingham

by fax (08) 6595 8880 or email hello@headspacerock.com.au.

* Please note: We are unable to provide psychological assessments or reports for another purpose (e.g. in relation to Workers Compensation, Centrelink or Family Court matters).

|  |  |  |  |
| --- | --- | --- | --- |
| **Official Document Control** | | | |
| **Version Number** | **Purpose/change** | **Approver** | **Date** |
| 1 | Revision | Executive Manager | 2/09/2019 |