headspace Strathpine referral form

Please return to:
Email: headspace.strathpine@openminds.org.au
Fax: (07) 3465 3099
Address: 441 Gympie Road, Strathpine 4500

Important information regarding your referral, **please read:**		
• headspace Strathpine is a service for young people between the ages of 12 to 25. We can only engage with young people who have provided consent to the referral. • If the young person is at high or acute risk of suicide, please contact emergency services on 000. • Please note that receipt of the referral form does *not* indicate acceptance to the headspace Strathpine services. Suitability of the referral will be determined following assessment with the young person. • To complete the referral, you must attach relevant assessment notes, discharge summaries and/or additional information. • We will endeavour to respond to referrals within 24-48 hours if received during business hours		
Consent for Referral		
Has the young person consented to and provided permission to exchange information in relation to this referral?	☐ Yes	☐ No
Primary Reason(s) for Referral: This section must be completed.		
☐ Short Term Mental Health Intervention	☐ Drug and/or Alcohol Support	
☐ Vocational Support	☐ Physical Health Support	
☐ Other:		
Referrer Details: headspace will be corresponding with you using the below details. Please ensure that all details listed below are correct and legible.		
Name of Referrer: Relationship to Young Person: Contact Number:	Organisation: Designation: Fax Number:	
Service Address: Email Address: Do you want to be added to our mailing list:	☐ Yes	☐ No
Parent/guardian: Please note that if the young person is aged 16 and under, we will require a parent or legal guardian to be documented on this form and attend the first appointment.		
Name:		
Relationship to young person:		
Contact Number:		
Do we have permission to speak with this person:	☐ Yes	☐ No

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Young Person's Details:		
Name: Date of Birth: Gender: Address: Suburb: Contact Number (1): Medicare Card Details: Expiry Date: Interpreter Required: Assistance with Reading/Writing?	 Age: Post Code: Contact Number (2): ☐ Yes Language: ☐ Yes	 ☐ No ☐ No
Presenting Issues		
Current Presenting Issues (Please include duration, age of onset and any other relevant information)		
Impact on functioning (eg: relationship/school/home/work/decline in function)		
Known family history of mental health conditions		
Previous/current engagement with other services: (please attach all relevant assessment/notes)		

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Risk Factors			
☐Suicide	☐Non-Accidental Self-Injury	☐Harm to Others	☐Social Withdrawal
☐Homelessness	☐Substance use	☐Misadventure	☐Non-Compliance

Please Provide Details Below:

Referrer's Name:
Referrer's Signature:
Date:
By signing this document, the referrer agrees that the above information is a true and accurate record