referral form

headspace Woolloongabba

ELIGIBITY CRITERIA:

- **Referral from Service Providers** **will require a copy of ALL relevant collateral information** *(including any assessments, discharge summaries & recovery documents)* **prior to the referral being triaged.**
- General Practitioners can fax and/or email a Mental Health Care Plan to headspace Woolloongabba instead of completing this referral form
- Referrals from **Probation and Parole** require social history, information on convictions and pending legal matters including dates, **prior to referral being triaged**. Please note we are a voluntary service.
- All referrals will be triaged by the Clinical Team to assess eligibility and suitability for headspace Woolloongabba
- Outcome of referral will be provided directly to Service Provider via email, telephone and/or fax
- headspace Woolloongabba works **under the Medicare Billing Model (MBS)**, which means young people are **eligible for up to 10 Sessions** with Private Practitioners (Psychologists, Social Workers, Occupational Therapists) per calendar year
- headspace Woolloongabba also has access to **Psychological Therapies Program** Practitioners (Psychologists, Social Workers, Occupational Therapists) onsite where a young person can access up to 12 sessions if assessed to meet the criteria by the Clinical Team
- For further information on services available at headspace Woolloongabba please access our website

1. REFERRER (INDIVIDUAL COMPLETING THIS DOCUMENT)

Contact Name: _____

Position / Role: _____

Organisation: _____

Postal Address: _____ Postcode: _____

Phone: _____ Mobile: _____ Fax: _____

Email: _____

Signed: _____

2. YOUNG PERSON BEING REFERRED (THESE DETAILS WILL BE USED TO CONTACT THE YOUNG PERSON/PARENT, FAMILY MEMBER, CARER)

First Name: _____ Surname: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

Suburb: _____ Postcode: _____ State: _____

Home Ph: _____ Mobile: _____

If Consent provided by young person, please provide details of their Parent/Family member/Carer:

Name: _____ Relationship to young person: _____

Mobile: _____

NOTE TO REFERRER

Please provide as much information as possible as it ensures the best quality of care, outcome and if required referral is afforded to the young person being referred.

If the young person is experiencing high levels of distress which may result in harm to themselves or others, please refer them directly to their local Emergency Department as headspace is not a Crisis Service or equipped to manage these types of emergencies.

3. REASON FOR REFERRAL

☐ Mental Health ☐ Physical Health ☐ Vocational/Social ☐ Alcohol/Other Drugs

☐ headspace Early Psychosis ☐ Other (please specify): _____

4. INFORMATION ABOUT THE YOUNG PERSON

(If Applicable) Risk to self or others (Include self-harm/suicide attempts, violence, threats of violence, vulnerability, child safety orders).

Date	Presenting issue	Previous Treatment	Current Treatment

(If Applicable) Other Agencies/Health Care Providers who are currently involved with the Young Persons Care: (e.g. Government, Non-Government, Psychiatrists, GP's and Community Services)

Name of Organisation	Contact Person	Address	Phone

5. PRESENTING ISSUES

☐ ADHD / ADD
☐ AGGRESSION
☐ ALCOHOL MISUSE
☐ ANXIETY
☐ AUTISM SPECTRUM DISORDER
☐ BODY IMAGE CONCERNS
☐ BULLYING
☐ CONTACT WITH CHILD SAFETY
☐ DEPRESSION
☐ DOMESTIC VIOLENCE
☐ DRUG MISUSE
☐ EATING ISSUES
☐ EMOTIONAL ABUSE
☐ EMPLOYMENT DIFFICULTIES
☐ FAMILY DIFFICULTIES
☐ FINANCIAL DIFFICULTIES
☐ INTELLECTUAL DISABILITY
☐ OBSESSIVE COMPULSIVE BEHAVIOURS
☐ OTHER
☐ PENDING LEGAL MATTERS
☐ PHYSICAL ABUSE
☐ PHYSICAL DISABILITY
☐ PRESENTATION TO E.D.
☐ PSYCHOSIS
☐ PTSD / TRAUMA HISTORY
☐ RELATIONSHIP ISSUES
☐ SCHOOL REFUSAL
☐ SELF-HARM
☐ SEXUAL ABUSE
☐ SOCIAL DIFFICULTIES
☐ STRESS
☐ SUICIDAL

Please provide relevant information:

6. Consent Of Young 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.

Please NOTE: Referrals will not be processed without signed consent.

I give permission for headspace Woolloongabba to use my contact details above for future contact with me. ☐ Yes ☐ No

I give permission for the **staff** of headspace Woolloongabba to obtain relevant information from referrer pertaining to this referral ☐ Yes ☐ No

I give permission for headspace Woolloongabba to contact the referrer and advise once an appointment has been arranged. ☐ Yes ☐ No

Signed: _____ Print Name: _____ Date: _____

If under 18 years of age authorisation ideally should be provided by a parent/guardian.

Parent/Guardian Signed: _____ Print Name: _____ Relationship: _____

7. Thank You For Your Referral

Please return this form to headspace Woolloongabba

Ph: 07 3249 2222
Fax: 07 3038 3090
Email: headspace.Woolloongabba@stride.com.au
Address: 182 Logan Road, Woolloongabba, QLD 4102

8. What Next?

- On receipt of a referral headspace Woolloongabba will contact the service provider to advise of outcome and then if applicable will contact the young person for a phone triage and/or in addition to arrange a face to face appointment.
- All triage contact will be with a headspace Woolloongabba Intake Clinician.