Referral Form

headspace Batemans Bay

Date: _____

Please Read: Important information for your referral.

- headspace 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 the Mental Health Line on **1800 011 511** or emergency services on 000 if urgent.
- Please note that receipt of the referral form does *not* indicate acceptance to the headspace services. Suitability of the referral will be determined following assessment with the young person. Please contact headspace Batemans Bay to confirm receipt and discuss the outcome of your referral.
- Where applicable please attach relevant assessment notes, discharge summaries and /or additional information.

Consent to Referral

Has the young person given consent for the referral?	☐ Yes	☐ No	
Have the young person's parents consented to the referral?	☐ Yes	☐ No	☐ Not applicable (14 years +)
Are parents aware that they will need to attend appointments	☐ Yes	☐ No	☐ Not applicable (14 years +)
Does the YP have a Mental Health Care Plan?	☐ Yes	☐ No	

Young Persons' Details:

Name: _____ Contact Number: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: _____ Pronouns: _____

Address: _____

Suburb: _____ Post code: _____ Email address: _____

Does the young person identity as:

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander

☐ Culturally & Linguistically Diverse (CALD) ☐ LGBTQIA+ ☐ Transgender

Does the young person have any difficulties with literacy?

☐ No ☐ Yes, please explain: _____

_____

Parent / Guardian / Next of kin details:

Name: _____ Contact Number: _____

Relationship to young person: _____

Address: _____

Suburb: _____ Post code: _____

Medicare Details:

Medicare card number: _____ Individual Reference: _____ Expiry: _____

Referrer Details

Name of Referrer: _____

Organisation: _____

Relationship to young person: _____

Contact Number_____ Email: _____

Address: _____

Suburb: _____ Post code: _____

Presenting issues:

☐ Anger ☐ Anxiety ☐ Bullying ☐ Depression ☐ Relationships

☐ Self-harm ☐ Stress ☐ Substance misuse ☐ Suicidal ideation ☐ Trauma

☐ Other, please provide details: _____

_____

_____

Referral information (please complete this section)

Please attach any extra relevant information and assessments e.g., Risk Assessment, A1, Discharge Summary

Thanks for making a referral to headspace Batemans Bay. You can return the referral form by:

Fax	**Email**
(02) 9169 3478	info@headspacebatemansbay.org.au

We will acknowledge your referral within 2 business days of receipt. If the young person gives consent, we will communicate with you that they are accessing service at headspace Batemans Bay.