

**Agency Referral Date: \_\_\_/\_\_\_/\_\_\_\_\_\_**

**Young Person’s Details:**

**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 Fremantle?**

(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**

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

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

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

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**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

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

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**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** Fremantle will attempt to notify the referring agency with the recommendations.
* On receipt of this form, **headspace** Fremantle will contact the young person to discuss support options available.
* With consent from the young person, **headspace** Fremantle will advise the referring agency of the young person making an initial appointment.
* If **headspace** Fremantle is unable to contact the young person, they will notify the referring agency.
* If you need further information, please contact **headspace** Fremantle on (08) 9431 7453.
* Please forward completed this form and all supporting documentation to **headspace** Fremantle

by fax (08) 6210 1152 or email intake@headspacefreo.com.au.

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