**Referral Guidelines**

**About headspace Kalgoorlie**

**headspace** Kalgoorlie is a free, youth-friendly and confidential service for young people aged 12 – 25 years.

Lead by Hope Community Services, **headspace** Kalgoorlie, brings together a range of services, to provide a holistic “one-stop-shop” for young people. We offer information, intake, assessment and referral. **At headspace** Kalgoorlie we offer the following supports and services including:

|  |  |
| --- | --- |
| * Youth Friendly Nurse Practitioner | * Telepsychiatry Service |
| * Youth Counselling | * Alcohol & Drug Education Counsellors |
| * MBS & ATAPS Psychological Services   *(Under GP Mental Health Treatment Plans)* | * Support Groups   *Young Parents*  *Significant Others*  *Homework Club* |
| * Youth Career Guidance Support |  |

**PLEASE NOTE:**

**headspace Kalgoorlie is not an acute mental health/crisis service. If you have any immediate concerns regarding the safety/wellbeing of a young person, please call: Mental Health Emergency Response Line (MHERL) on 1800 555 788; Lifeline on 13 11 14; or Kids Helpline on 1800 55 1800. In an emergency, contact 000 immediately.**

**HOW TO REFER:**

**Self-Referral**

Young people are encouraged to make contact with the headspace Kalgoorlie service directly.

**By phone/email**

Call (08) 9021 5599 within office hours or email [hKalAdmin@hopecs.org.au](mailto:hKalAdmin@hopecs.org.au), a worker will contact the young person to make an appointment within 1 – 3 working days.

**Drop in**

Young people can call into **headspace** Kalgoorlie, Level 1/ 48 Brookman Street, Kalgoorlie, between 10am and 5pm, Monday – Friday. Staff will endeavour to see the young person the same day or the next available appointment will be offered.

**Professional Referral**

GP’s, Allied Health Professionals, community-based agencies and educational institutions can all refer young people to **headspace** Kalgoorlie using the Referral Form attached. General Practitioners should include a mental health care plan (if appropriate) for the young person and attach this to the **headspace** Kalgoorliereferral form.

**Family Referral**

Families, carers or friends can refer a young person to **headspace** Kalgoorlie. The young person needs to be aware of and consent to the referral and be willing to meet with a member from the **headspace** Kalgoorlie team. Once receipt of referral has been confirmed, a worker will contact the young person within one to three working days to make an appointment. Families, parents or carers who have a young person engaged with **headspace** Kalgoorlie can also access our centre to discuss service provision.

For more information regarding **headspace** Kalgoorlie, please contact us directly or visit our website at [www.headspace.org.au/kalgoorlie](http://www.headspace.org.au/kalgoorlie).

**PLEASE COMPLETE BOTH SIDES OF THIS FORM**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Referral:** |  | | | | **Is client aware of referral?** | | | | Yes  No | |
| **Referral Type:** | Walk in Phone  Email  Fax | | **Referral Source:** | | Self Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  School Friend/Family Member  Service Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Client Details** | | | | | | | | | | |
| **Name:** |  | | | | **DOB:** | |  | | | |
| **Address:** |  | | **Gender** | | Male  Gender Diverse  Intersex  Female  Indeterminate  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Mobile:** |  | | **Email:** | |  | | | | | |
| Indigenous Status  Pronouns? | | | | | | | | | | |
| **Do you suffer from any of the following health conditions?** | | | | | | | | | | |
| Diabetes  Heart Disease  Epilepsy  Lung Disease  Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Kidney Disease  Arthritis  Asthma  Low/high Blood Pressure  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| **Emergency Contact Details** | | | | | | | | | | |
| **Name:** |  | | **Phone:** | |  | | | | | |
| **Address:** |  | | **Email:** | |  | | | | | |
| **Relationship:** |  | | **Can we contact this person about your appointments?** | | | | | | | Yes  No |
| **Referrer’s Details** | | | | | | | | | | |
| **Referrer’s Details:**  Same details as Emergency Contact | | | | | | | | | | |
| **Name:** |  | | | **Relationship:** | | | |  | | |
| **Address:** |  | | | **Organisation:** | | | |  | | |
| **Phone:** |  | | **Email:** |  | | | | | | |
| **Can we contact this person about your appointments?** | | | | | | Yes  No | | | | |
| **Reason/s for Referral:** | | Mental Health  Drugs and Alcohol  School/Work  General Health | | | | | | | | |
| **Can you tell us a little more?** | |  | | | | | | | | |

|  |  |  |
| --- | --- | --- |
| **Client Consent** | | |
| * A part of the referral process to headspace Kalgoorlie is for us to learn about you and the other services involved in your life. * All information we find out about you, including from the HAPI (iPad) survey, will be treated confidentially, which means we will not share your information with anyone else unless you give us permission or you are at serious risk. * I am involved in the following services and I consent (give my permission) to headspace Kalgoorlie to obtain the relevant information from the following people: | | |
| CAMHS (Child and Adolescent Mental Health Service) | CMHS (Community Mental Health Service) | |
| GP – Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Practice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Not For Profit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| High School Psychologist/Chaplin/Counsellor:  KBC  EGC GBC JPC  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Primary School Psychologist/Chaplin/Counsellor:  School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Government Service:  Department of Child Protection and Family Support\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Youth Justice\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Adult Community Corrections:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  WA Police\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Anyone else you can think of?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * I am aware that this referral is being made. I understand I can withdraw from headspace Kalgoorlie at any time. | | Yes  No |
| * I understand that any information collected by headspace is stored confidentially. I give my permission for headspace Kalgoorlie to obtain relevant information from the people listed above and from the HAPI (ipad) survey conducted at the beginning of every appointment. | | Yes  No |
| **Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| If the young person **is under 16 years of age**, authorisation should (where possible) be provided by a parent/guardian/carer.  **Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |