Client Referral Form for Professionals

Referral Date:

headspace Contact Details	Fax	Phone
Murray Bridge	(08) 8531 2426	(08) 8531 2122

Referral Guidelines

headspace Murray Bridge is funded by Country PHN, and administered by Murray Mallee GP Network, to provide a range of services for young people aged 12- 25 years, within the Murray Mallee region.
headspace Murray Bridge provides free, youth friendly and confidential service to young people aged 12-25 years.
headspace Murray Bridge aims to be a one-stop-shop for young people with mild -moderate physical, psychological or social difficulties, and young people with complex care needs not meeting the criteria for Tertiary Government Mental Health Services, i.e.- not high risk, but needing support in multiple domains.

The services available at headspace Murray Bridge include:

- **Psychosocial Support -** group programs including Hangout Space, young mums, LQGBTI group, Youth Reference Group, and a range of other special interest groups which vary each term.
- **Brief Intervention Programs** (6 Session Low Intensity Cognitive Behavioural Therapy) - for mild MH issues, and may be offered to young people while on Waitlist.
- **Counselling -** for clients with Mild-Moderate Mental Health concerns under MHCP- by private providers at **headspace**, no cost (6+4 sessions/ year).
- **Mental Health** support by Allied Health Professionals, Mental Health Clin
- **Complex Care** – is for clients with severe mental health concerns in multiple areas, who are not considered at high risk of harm to self or others. Care co-ordination include organising services and support provision to ensure the young person has evidenced based care.
- **Tele-psychiatry -** for current **headspace** clients.
- **GP-** for medical issues, mental health and sexual health.

Please note- we are unable to provide medico-legal reports but may be able to provide a note of attendance.

Important Information

Important information regarding your referral, <u>please read</u>:
In order for us to process this referral promptly, please ensure that you have included all relevant information in leasable print.

- **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.
- **headspace** is not a crisis/ acute mental health service. If the young person is at high or acute risk of suicide or harm to others, please contact emergency services on 000.
- **Please note that receipt of the referral form does *not* indicate acceptance to the headspace services**. All referrals are reviewed by the Triage and Liaison Worker, who contacts referrer if more information is needed, and discusses the referral with the young person/ and or parents/ caregivers to ascertain best pathway for the young person. Referrals may be forwarded to an external service at times to best meet the young person's needs. If you have any queries pertaining to your referral, please phone our service.
- **Waitlist**- given the demand for **headspace** services, there may be a waitlist at times. You will be advised by the Triage and Liaison Worker at the time of your triage phone call. This waitlist is not monitored, and we request that you seek urgent help from your GP or local hospital should your situation change. We recommend a list of services which young people can access while they are on the waitlist, including **eheadspace** and Beyond Blue.

Young Person's Details ***PLEASE PRINT CLEARLY USING A BLACK PEN***

Full Name: _____ **Previous client?** yes ☐ no ☐ unk ☐

Date of Birth: _____ **Age:** _____ **Gender:** Male ☐ Female ☐ Non-Binary ☐ Transgender ☐

Client Address: _____

_____

Contact Number*(s)*: _____ **Email:** _____

Centrelink Status:

Unemployment Benefit ☐ Disability Support Pension ☐ Sickness Benefit ☐ Youth Allowance ☐ Student ☐

Other *(please specify)* ☐ _____ No Benefits ☐

Aboriginal or Torres Strait Islander? Yes ☐ No ☐ **Country of Birth** _____

Client's Key Contact Person *(in case of emergency)*

Name: _____ Relationship to young person: _____

Contact Number(s): _____

Address: _____

Referrer's Details

Referrer Full Name: _____ **Contact Number:** _____

Email Address: _____

Workplace: _____

Is the young person involved in any Legal Issues? Yes ☐ No ☐ *(If yes, please specify below)*

Reason for Referral *(What is the main problem that the young person is seeking help with?)*

*(**health professionals**- please attach current Risk Assessment, Mental State Examination, summary of care episode and service requested), (educational/housing services- please include safety assessment and current summary of care)*

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Other Information

Has the young person been asked to attend a GP to get a Mental Health Care plan? *(strongly recommended)*

Yes ☐ No ☐

Does the young person have an existing GP? Yes ☐ No ☐ *(If yes, please fill in the details below)*

Doctor's Name: _____

Practice Name: _____ Phone:_____

Medicare Details (*include position and expiry date*): _____

Consent

Client is aware of referral, has given consent and wants to attend headspace: Yes ☐ No ☐

PRIVACY If the young person does not want their parents or carers to know about them accessing our services, please let us know and we will note this on their file. (*Young people aged **under 16 years need to have a responsible adult involved***) Doesn't Mind ☐ Keep Private ☐

OFFICE USE ONLY

Referral Received Date/Time_____ **Entered to Mastercare by**_____