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| **Important information regarding your referral, please read:** |
| * **headspace** Redcliffe 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 emergency services on 000. * Please note that receipt of the referral form does *not* indicate acceptance to the **headspace** Redcliffe services. Suitability of the referral will be determined following assessment with the young person. Please call **headspace** Redcliffe to confirm receipt and discuss the outcome of your referral. * To complete the referral, you must attach relevant assessment notes, discharge summaries and/or additional information. * We will endeavour to respond to referrals within 24-48 hours if received during business hours. |

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| **Consent for referral:** |  |  |
| Has the young person consented to and provided permission to exchange information in relation to this referral? | **Yes** | **No** |

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| **Primary reason(s) for Referral:** This section must be completed. Please contact us if you have any queries regarding available services. | |
| Short-term Mental Health Intervention with **headspace** Redcliffe Primary Care Team  Does the young person have a Mental Health Care Plan?  Yes  No | |
| Drug and/or Alcohol Support | Vocational Support |
| Physical Health Support | Other, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Referrer details:** **headspace** will be corresponding with you using the below details. Please ensure that all details listed below are correct and legible. | | | |
| Name of Referrer: | Click here to enter text. | Organisation: | Click here to enter text. |
| Relationship to Young Person: | Click here to enter text. | Designation: | Click here to enter text. |
| Contact Number: | Click here to enter text. | Fax Number: | Click here to enter text. |
| Service Address: | Click here to enter text. | | |
| Email Address: | Click here to enter text. | | |
| Do you wish to be part of our mailing list?  Yes  No | | | |

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| **Parent/guardian:** Please note that if the young person is aged 16 and under, we will require a parent or legal guardian to be documented on this form and attend the first appointment. | | | | |
| Name: | Click here to enter text. | | |
| Relationship to young person: | Click here to enter text. | Contact Number: | Click here to enter text. | |
| Do we have permission to speak with the person identified?  Yes  No | | | | |

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| **Young Person’s Details:** | |
| Name: | Click here to enter text. |
| Date of Birth: | Click here to enter text. Age: Click here to enter text. Gender: Click here to enter text. |
| Address: | Click here to enter text. |
| Suburb: | Click here to enter text. Post code: Click here to enter text. |
| Contact Number 1: | Click here to enter text. 2. Click here to enter text. |
| Medicare Card Details: | Expiry Date: |
| Interpreter Required? | Yes, Language:   No |
| Assistance with Reading/Writing? | Yes  No |

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| **Presenting Issues:** |
| **Current presenting issues (please include duration, age of onset, and relevant pre-existing diagnoses):**  Click here to enter text. |
| **Impact of problem on functioning:** (e.g. relationships/school/home/work)  Click here to enter text. |
| **Please indicate if there is any known family history of mental health conditions:**  Click here to enter text. |
| **Previous/current engagement with other services:** (if current and referrer, assessment information must be attached)  Click here to enter text. |
| **Risk Factors:** |
| Suicide  Non-accidental self-injury  Harm to others  Extreme social withdrawal  Homelessness  Substance use  Accidental Death  Non-compliance |
| **Please provide details:**  Click here to enter text. |

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| Referrer’s Signature/Name: |  |
| *By signing this document, the referrer agrees that the above information is a true and accurate record.* | |
| Date: |  |

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| **OFFICE USE ONLY**  ***When booking appointment, please request that the YP attends 15 minutes prior to their appointment time*** |
| Book with Intake Clinician Date/Time:  Clinician: |
| Declined/Referred Elsewhere Recommendations Made: Click here to enter text. |