**headspace Platform Gosford, Lake Haven and Wyong**



**Referral form**

For any inquiries, please call us at **Gosford 4304 7870, Lake Haven 4394 9100 (Mon-Fri)**

**or Wyong 4394 9180 (Tues-Thurs)**

Please fax referrals to **headspace** Lake Haven on 4394 9111 or Gosford 4304 7899

or email cclhd-headspace-info@health.nsw.gov.au

**Important information about your referral**

headspaceis a service for young people aged 12-25

We can only provide support to young people who agree and consent to the referral being made.

headspace Gosford, Lake Haven and Wyong, **are NOT acute mental health or a crisis service**

If you have any immediate concerns for yourself as a young person, or for the young person you are referring, please call the Mental Health line on **1800 011 511**

Alternatively you, or the young person you are referring, can present to the Emergency Department at the nearest hospital, or call 000

For crisis counselling telephone support please contact **Lifeline** on **13 11 14, Kids Helpline** on **1800 55 1800** or

**13YARN** on **13 92 76**

Completing this referral form does not mean the young person is accepted into the service. headspace

headspace will aim to respond to your referral within 3 business days

**Young Person’s Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Preferred headspace site: | Gosford | Lake Haven | Wyong |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name: |  |  | | Date of Birth: |  | |
| Address: |  | |  | |  |  |

Is it okay for us to send **headspace** branded documents to this address? Yes  No

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: |  | email: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Gender: |  | Preferred pronoun/s: |  | Medicare No: |  | Exp: | / |

|  |  |  |  |
| --- | --- | --- | --- |
| Next of Kin/Emergency Contact: |  | |  |
|  | *Name:* | | *Phone number:* |
| Relationship: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Does the young person identify as Aboriginal or Torres Strait Islander? | Yes  No | If yes, traditional place name? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| What Culture does the young person identify  with  Does the young person require an interpreter | Yes  No | If yes, which language? |  |

|  |  |
| --- | --- |
| Does the young person have an existing GP? | Yes  No |

|  |  |  |  |
| --- | --- | --- | --- |
| Doctor’s name: |  | Practice Name: |  |

**Referrers Details**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name: |  | |  |  | Phone: |  |
| email: | |  | | | | |

|  |  |
| --- | --- |
| Relationship to young person: |  |
|  | *Organisation (if applicable)* |

**Consent**

|  |  |  |
| --- | --- | --- |
| Does the young person consent to this referral? | Yes  No |  |

**Reason for Referral**

What are some of the current issues? *(please include info about pre-existing diagnosis, duration of current issues etc)*

What has been the impact of these? *(eg relationships, school, work, home etc)*

What are the young person’s goals and objectives in seeking support from headspace?

Is there a family history of mental health? *If yes, please provide details*

|  |  |
| --- | --- |
| Is the young person currently supported by other health services? *(If so, please provide service details below)* | Yes  No |
| |  | | --- | |  |   Does the young person consent to **headspace** Gosford, Lake Haven and Wyong  exchanging information with these services to support this referral? | Yes  No |

**Risk Factors – current & previous**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Suicide |  | Alcohol & Drug Use |
|  | Self-Harm |  | Homelessness |
|  | Harm to Others |  | Extreme Social Withdrawal |
|  | Domestic Violence |  |  |

Please provide further details: eg recent suicide thoughts, plans, symptoms, behaviours, concerns from others about risk, at risk mental state (depressed, despair, hopelessness, guilt, marked agitation, intoxication)



**headspace service interest**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Welcome Support (information about headspace) |  | CRP-Case Management Support |
|  | Counselling Support (10 sessions) |  | GP/Nurse Clinic |
|  | Single Session (1 session + follow up phone call) |  | Work and Study Support |
|  | Brief Intervention (4 sessions) |  | Not Sure |
|  | Groups *(social, psych-educational)* |  |  |