Please note that **headspace Greensborough and Plenty Valley is not a crisis service**. Crisis care can be accessed via;
Under 18 Triage, 9am-5pm, Monday to Friday (Darebin, Whittlesea, Banyule, Nillumbik) 1300 859 789
North East MH Triage Service 24 hours (Banyule, Nillumbik): 1300 859 789
Northern MH Triage Service 24 Hours (Darebin, Whittlesea) 1300 874 243
Eastern MH Triage Service 24 hours (Manningham): 1300 721 927

headspace Greensborough offers early intervention support for young people aged 12-25 years.

Date:

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|  **Young Person’s Details** Young person is aware about and agrees to referral: [ ]  Yes |
| Title: | Name: |
| Gender identity: | Pronouns: | DOB: |
| Address: |
| Phone: | Email:  |
| Preferred mode of contact: [ ]  SMS [ ]  Phone call [ ]  Email [ ]  Letter |

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|  Young Person’s Language and Culture |
| Tick any that apply:  | [ ]  Aboriginal [ ]  Torres Strait Islander [ ]  Culturally and Linguistically Diverse |
| Does the young person require an interpreter? [ ]  No [ ]  Yes, please state what language (including Auslan): |

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| **Emergency Contact** |
| Name: | Phone: |  |
| Relationship to young person:  |  |  |
| If no emergency contact provided, please provide rationale |  |  |

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| **Referrer Details** |
| Name: | Role: |
| Phone: | Agency: |
| Fax: | Email:  |

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| Referral Information |
| Does the young person have a Mental Health Plan? [ ]  No [ ]  Yes |
| Other organisations/supports in place (i.e. GP, school wellbeing, family services – please include role and contact information)   |

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| **Presenting concerns**  |
| *Eg*. *Current issues, duration of concerns, level of impact etc.*  |
| **Reason for referral** |
| [ ]  Brief interventions with counsellors (approx. 6 sessions, goal focused). **\*This is for people going through a tough time but not for those with very complicated mental health issues Please note that this support is unsuitable for people needing specialist or long-term supports.**[ ]  headstart (Single Session Therapy) [ ]  Employment support[ ]  Alcohol or other drug support [ ]  Physical/ sexual health consultation[ ]  Groups[ ]  Other, please comment below;   |

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| **Relevant background and additional information**  |
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| **Risk and safety concerns** |
| [ ]  Suicidal ideation [ ]  Historic or current suicidal behaviours [ ]  Non suicidal self-injury or self-harming behaviours [ ]  Alcohol or other drug use[ ]  Risk taking behaviours[ ]  Historic or current family and/or domestic violence[ ]  Safety plan completed (please attach with referral)Comments (if yes, please provide more information); |

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| **Consent** |
| I, [carer’s name if young person under 16, young person’s name if 16 or over], give consent for this referral to be made and give permission for \_\_\_\_\_ [referrer name] to exchange information with headspaceGreensborough for the purpose of this referral.Young person/carer signature: Date: OR Tick if verbal consent was obtained [ ]  |

Please send through any relevant documentation with your referral (i.e. MHCP, assessments or discharge plan) via email to: headspacegreensborough@mindaustralia.org.au or fax: 03 9435 8621