# Referral Form

| | | | |
|---|---|---|---|
| **headspace Griffith is a voluntary service for young people aged 12 – 25 years. headspace can only engage with the young person if they have consented to the referral. Please ensure all sections are completed and legible.** | | | |
| Date of Referral? | | | |
| Is the young person aged 12 – 25 years of age? | | Yes ☐ | No ☐ |
| Has the young person consented to the referral? | | Yes ☐ | No ☐ |
| **Details of Young Person** | | | |
| Does the young person consent to provide the following information to headspace and it being store in headspace's client management system and hAPI? | | Yes ☐ | No ☐ |
| If the young person is under 14 years of age, have the parents or carers of the young person consented to the referral as well? | | Yes ☐ | No ☐ |
| First Name | | Surname | |
| Preferred name | | Gender | |
| Date of Birth | | Pronouns | |
| Address | | Suburb | Postcode |
| Phone (Home) | | Mobile | |
| Email | | | |
| Preferred Method of Contact | Email ☐ | Phone ☐ | SMS ☐ |
| Nationality | | | |
| Interpreting Service Required? | Yes ☐ | No ☐ | Preferred Language |
| Do you identify as | Aboriginal ☐ | Torres Strait Islander ☐ | Aboriginal & Torres Strait Islander ☐ |
| **Emergency Contact (we will contact this person if we are concerned about the young person's safety)** | | | |
| Parent/ Carer/ Guardians Details | | | |
| First Name | | Surname | |
| Address | | Suburb | Post Code |
| Phone (Home) | | Mobile | |
| **Details Of Referrer (please ensure this section is completed) Please tick if same as above ☐** | | | |
| Name of Referrer | | Organisation | |
| Address | | Suburb | Post Code |
| Phone (Business Hours) | | Phone (Mobile) | |
| Email | | Relationship to the young person | |

# Referral Form

**Reason/s for Referral**

| Wellbeing & Mental Health ☐ | General or Sexual Health ☐ | Alcohol & other Drugs ☐ | Work, School, Study ☐ |
|---|---|---|---|

**Main Issue/s**

**Relevant Past History**

| | | | |
|---|---|---|---|
| Additional information supplied /attached? Mental Health Treatment Plan / Discharge summary etc? | | Yes ☐ | No ☐ |
| Does the young person currently see any other services? If yes, please tick appropriate box/ boxes | | Yes ☐ | No ☐ |
| Drug and Alcohol ☐ | Child Protection ☐ | School/ Other Counsellor ☐ | Child/ Adolescent Mental Health ☐ |
| Corrective Services ☐ | Adult Mental Health ☐ | Allied Health/ Non-Government Support ☐ | Specialist Medical Services (Psychiatrist/ Paediatrician etc) ☐ |
| Other – Please Specify | | | |
| Does the young person have a regular GP? If yes, please provide details below | | Yes ☐ | No ☐ |
| Name of GP | | Contact Details | |
| Name of Medical Practice | | Phone | |
| Is the other service aware of the referral to headspace? | | Yes ☐ | No ☐ |
| Will the services currently involved continue working with the young person? | | Yes ☐ | No ☐ |

**If the young person is experiencing current;**

- **Suicidal thoughts**
- **Suicidal plan**
- **Suicidal intent**

**Please contact Accessline on 1800 800 944 instead of making this referral as headspace is not a crisis service.**

**Thank you**

**1/26 Ulong Street Griffith NSW 2680** **T: 02 6962 3277** **email: enquiries@headspacegriffith.org.au**

headspace National Youth Mental Health Foundation is funded by the Australian Government Department of Health ABN 7261040348