|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Referral:** |  | | | | **Is client aware of referral?** | | | | ☐ Yes ☐ No | |
| **Referral Type:** | ☐Walk in ☐Phone  ☐Email ☐ Fax | | **Referral Source:** | | ☐Self ☐Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐School ☐Friend/Family Member  ☐Service Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Client Details** | | | | | | | | | | |
| **Name:** |  | | | | **Date of Birth:** | | |  | | |
| **Address:** |  | | | | **Place of Birth:** | | |  | | |
| **Suburb:** |  | | **Gender:** | | ☐ Male ☐ Gender Diverse ☐ Unsure  ☐ Female | | | | | |
| **Mobile:** |  | | **Ethnicity:** | |  | | | | | |
| **Health Care Card** | **No: Expiry**: | | | | | | | | | |
| **Medicare** | **No: Reference: Expiry:** | | | | | | | | | |
| **Do you suffer from any of the following health conditions?** | | | | | | | | | | |
| ☐ Diabetes ☐ Heart Disease ☐ Epilepsy ☐ Lung Disease ☐ Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ Kidney Disease ☐ Arthritis ☐ Asthma ☐ Low/high Blood Pressure  ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| **Emergency Contact Details** | | | | | | | | | | |
| **Name:** |  | | **Phone:** | |  | | | | | |
| **Address:** |  | | **Email:** | |  | | | | | |
| **Relationship:** |  | | **Can we contact this person about your appointments?** | | | | | | | ☐ Yes ☐ No |
| **Referrer’s Details** | | | | | | | | | | |
| **Referrer’s Details:** ☐ Same details as Emergency Contact | | | | | | | | | | |
| **Name:** |  | | | **Relationship:** | | |  | | | |
| **Address:** |  | | | **Organisation:** | | |  | | | |
| **Phone:** |  | | **Email:** |  | | | | | | |
| **Can we contact this person about your appointments?** | | | | | | ☐ Yes ☐ No | | | | |
| **Reason/s for Referral:** | | ☐ Mental Health ☐ Drugs and Alcohol ☐ School/Work ☐ General Health | | | | | | | | |
| **What has prompted you to make contact with headspace?** | | *Example : feeling stressed and anxious.* | | | | | | | | |

**PLEASE COMPLETE BOTH SIDES OF THIS FORM**

|  |
| --- |
| **Client Consent** |
| * A part of the referral process to headspace Hervey Bay is for us to learn about you and the other services involved in your life. * All information we find out about you, including from the HAPI (iPad) survey, will be treated confidentially, which means we will not share your information with anyone else unless you give us permission or you are at serious risk. **(Clinician to discuss limits to confidentiality with client).**   **LIMITS TO CONFIDENTIALITY**   * *You are being seriously hurt by someone* * *You are thinking of seriously harming yourself* * *Someone else is being, or likely to be, seriously hurt by you or another person* |
| * I consent (give permission) to **headspace Hervey Bay** to obtain/share **relevant** information with the following people:   **(Discuss this point with your Access and Engagement Clinician)**  ☐ CYMHS (Child and Youth Mental Health Service) ­­  ☐ CMHS (Community Mental Health Service)  ☐ Government Service:  ☐ Department of Communities, Child Safety & Disability Services \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ Youth Justice\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ Qld Corrective Services (inc Probation & Parole) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ Qld Police\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ GP – Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ph:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ School Psychologist /Chaplain/ Counsellor:  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ph:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ Anyone else you can think of? |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| * I consent to referrals being made on my behalf. * I understand I can withdraw from headspace Hervey Bay at any time. | | | | | ☐ Yes  ☐ Yes | |
| * I understand that any information collected by headspace is stored confidentially. I give my permission for headspace Hervey Bay to obtain/share relevant information from the people listed above and from the HAPI (ipad) survey conducted at the beginning of every appointment. | | | | | ☐ Yes ☐ No | |
| **If the young person is under 16 years of age, authorisation should (where possible) be provided by a parent/ guardian/ carer.** | | | | | | |
| Client name: |  | Signature: |  | Date: | |  |
| Guardian name: |  | Signature: |  | Date: | |  |
| Clinician name: |  | Signature: |  | Date: | |  |