|  |
| --- |
| **Young Person’s Details:** |
| **Name:** | **DOB:** | **Age:** |
| **Preferred Name (and pronouns):** | **Gender:** |
| **Address:**  |
| **Postal Address:** | **Town/Suburb:** |
| **E-mail:**  | **Phone:** |
| **Would you like to go on our mailing list to receive newsletters and surveys?** | Yes [ ]  | No [ ]  |
| **Is the young person under 16?** | Yes [ ]  | No [ ]  |
| **If under 16, is the parent/caregiver aware of the referral?** | Yes [ ]  | No [ ]  |
| **Do you identify as Aboriginal and/or Torres Strait Islander?** | Yes [ ]  | No [ ]  |
| **Is English the main language spoken at home?** | Yes [ ]  | No [ ]  |
| **If no, what is the main language?** | **Is an interpreter required?**  | Yes [ ]  | No[ ]  |
| **Country of birth:** | **Emergency Contact name:** |
| **Phone:** | **Relationship to young person:** |
| **Referrer Information: (Tick if details are the same as emergency contact)** [ ]  |
| **Name:** | **Phone Number:** |
| **Role & Organisation:** | **Relationship to young person:** |
| **E-mail:** |
| **Appointments: (Tick all that apply)** |
| **Preferred appointment method:** | In person [ ]  | Phone [ ]  | Digital [ ]  |
| **Who should be contacted to make appointments?** | Young person [ ]  | Referrer [ ]  | Emergency Contact [ ]  |
| **Do you consent to receive your pre-appointment survey via text message?** | Yes [ ]  | No [ ]  |
| **Does the young person have a Mental Health Treatment Plan?** | Yes [ ]  | No [ ]  |
| **Consent:** |
| *If the young person is under 16 years of age, a parent/guardian must provide consent.* |
| Do you consent for headspace to add the young person to our database? | Yes [ ]  | No [ ]  |
| **Consent type:** | Verbal [ ]  | Written [ ]  | **Name of person consenting:** |
| **Young person signature:** | **Date:** |
| **Parent/Guardian signature:** | **Date:** |
| **Referrer signature:** | **Date:** |

|  |
| --- |
| **Reasons for Referral:** |

**What are the main reasons for this referral?**

**How long has this been going on?**

**How is this impacting your/the young person’s daily life?**

**Have you/the young person accessed any mental health services before? (Please include any formal diagnosis).**

|  |
| --- |
| **Risk Factors:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Suicide** | No [ ]  | Thoughts [ ]  | Plan [ ]  | Intent [ ]  |
| ***Details:***  |
| **Self-Harm** | No [ ]  | Past [ ]  | Current [ ]  | Unknown [ ]  |
| ***Details:***  |
| **Harm to others** | No [ ]  | Yes [ ]  | Unknown [ ]  |
| ***Details:***  |
| **Other risk factors** (e.g. homelessness, substance abuse, social withdrawal, medication compliance) |
| ***Details:*** |