REFERRAL FORM

ELIGIBILITY CRITERIA:

- General Practitioners are able to fax/email a Mental Health Care Plan to headspace Nundah instead of completing this referral form.
- **Referral from Service Providers will require a copy of ALL relevant collateral information** *(including any assessments, discharge summaries & recovery documents)* **prior to the referral being triaged.**
- **headspace** Nundah works **under Medicare Benefit Schedule (MBS)**, this means clients are only **eligible up to 10 Sessions** with Private Practitioners (Psychologists and Clinical Psychologists). We also have a Psychiatrist and Dietitian on site, which can be accessed if deemed appropriate by Intake team.
- Referrals from **Probation and Parole** require social history, information on convictions and pending legal matters including dates, **prior to referral being triaged**.

1. REFERRER (INDIVIDUAL COMPLETING THIS DOCUMENT)

Contact Name: _____

Position / Relationship: _____

Organisation (if applicable): _____

Postal Address: _____

_____ **Post Code**_____

Phone: _____ **Mobile:** _____

Fax: _____ **Email:** _____

2. YOUNG PERSON BEING REFERRED (THESE DETAILS WILL BE USED TO CONTACT THE YOUNG PERSON /PARENT, GUARDIAN)

First Name: _____ **Surname:** _____

Date of Birth: _____ **Age:**_____ **Gender:** ☐ **M** ☐ **F** ☐ **Other**

Address: _____

Suburb: _____**Postcode:** _____ **State:** _____

Home Ph: _____ **Mobile:** _____

If consent provided by the young person (under 16), please provide details of their parent/ guardian:

_____

NOTE TO REFERRER

Please provide as much information as possible as it ensures the best quality of care, outcome and if required referral is afforded to the young person being referred.

If the young person is experiencing high levels of distress which may result in harm to themselves or others, please refer them directly to your local Emergency Department or a GP for immediate assistance as headspace is not a Crisis Service or equipped to manage these types of emergencies.

3. REASON FOR REFERRAL:

☐ **Physical Health** ☐ **Mental health** ☐ **Alcohol/Drug** ☐ **Vocational** ☐ **Assessment**

☐ **Other - please specify** _____

4. Information About The Young Person

(If Applicable) Risk to self or others (Include self-harm/ suicide attempts, violence, threats of violence)

Date	Type of Behavior	Reason for Behavior	Outcome/ Treatment Provided

(If Applicable) Other Agencies / health care providers currently involved within the individuals care: (e.g.: Government, non Government, GP's, Psychiatrists, and Community Services)

Name of Organisation	Contact Person	Address	Phone

5. Presenting Issues

- ☐ Anxiety
- ☐ Family Problems
- ☐ Physical Abuse
- ☐ Relationship Issues
- ☐ Harm or threats to others
- ☐ Domestic Violence
- ☐ Emotional Abuse
- ☐ Presentation to ED or Hospital
- ☐ Past or present contact with Child Safety
- ☐ Pain Management Issues
- ☐ Financial Difficulty
- ☐ Loss of Appetite
- ☐ Physical disability
- ☐ Sexual Abuse
- ☐ PTSD / Trauma History
- ☐ Social Problems at School
- ☐ Hallucinations and delusions
- ☐ ADHD / ADD
- ☐ Difficulty sleeping
- ☐ Eating Problems
- ☐ Drug Abuse
- ☐ Intellectually Impaired
- ☐ Body Image
- ☐ Bullying Others
- ☐ Crying
- ☐ Other _____
- ☐ Refusing School
- ☐ Depression
- ☐ Self Harm
- ☐ History of hospitalisation
- ☐ Stress
- ☐ Suicidal
- ☐ Pending Legal Matters
- ☐ Aspergers / Autism

Do you have any final comments or relevant information?

_____

_____

_____

_____

_____

_____

_____

_____

6. CONSENT OF YOUNG PERSON BEING REFERRED

I am aware that this referral is being made. I understand that I can withdraw from this referral or from the referred service at any time.

Please NOTE: Referrals will not be processed without signed consent.

I give permission for **headspace** Nundah to use my contact details above for future contact with me. ☐ Yes ☐ No

I give permission for the **staff** of **headspace** Nundah to obtain relevant information from government and non-government agencies, from doctors and other health professionals specifically relevant to my care whilst being a client of **headspace** Nundah. ☐ Yes ☐ No

I give permission for **headspace** Nundah to contact the referrer and advise once an appointment has been arranged. ☐ Yes ☐ No

Signed: _____ **Print Name:** _____ **Date:** _____

If under 18 years of age authorisation ideally should be provided by a parent/ guardian.

Parent/ Guardian Signed: _____ **Print Name:** _____ **Relationship:** _____

7. THANK YOU FOR YOUR REFERRAL

Please return this form to headspace Nundah

PO Box 263, Nundah, QLD 4012
1264 Sandgate Rd, Nundah
Ph 07 3370 3900
Fax 07 3370 3999

Email Headspace.Nundah@aftercare.com.au

8. WHAT NEXT?

- On receipt of a referral form **headspace** Nundah will contact the service provider to advise of the outcome and then if applicable contact the young person to arrange an appointment.
- All initial appointments will be with a **headspace** Nundah Intake Clinician, this process takes between 1 – 2 hours.