REFERRAL FORM

Please **fax or email** this Referral Form to the **headspace Darwin** Team
08 8931 5995 (fax) or headspacedarwin@anglicare-nt.org.au **Phone headspace Darwin** on 08 8931 5999

YOUNG PERSON BEING REFERRED — DATE OF REFERRAL:

Name: _____ DOB: _____ Gender: _____

Do you identify as: Aboriginal: ☐ Torres Strait Islander: ☐ Neither: ☐

Nationality: _____ Interpreter required: Yes / No Language if Yes: _____

Address: _____ Post code: _____

Home phone: _____ Mobile: _____ Email: _____

REFERRER (INDIVIDUAL COMPLETING THIS DOCUMENT):

Self-referral from Young Person: Yes / No

Referrer Contact name: _____ Relationship: _____

Organization (if applicable): _____

Phone: _____ Fax: _____ Mobile: _____ Email: _____

YOUNG PERSON'S CONSENT FOR FAMILY/CARER/FRIEND/OTHER INVOLVEMENT IN CARE: *(Nominated family/carer /friend/other, the young person would like to be involved in their care and/or bring to an appointment at headspace)*

Young Person Consent: Yes / No

1. Name: _____ Relationship: _____

Phone: _____ Mobile: _____ Email: _____

2. Name: _____ Relationship: _____

Phone: _____ Mobile: _____ Email: _____

EMERGENCY CONTACT: *(Nominated family/carer /friend/other who can be contacted as an Emergency Contact should this be required)*

Young Person Consent: Yes / No

Name: _____ Relationship: _____Phone:_____Mobile:_____

OTHER CONTACT: *Nominated family/carer /friend/other who Young Person may want as a Contact for reason other than those nominated above)*

Young Person Consent: Yes / No Contact Purpose: _____

Name: _____ Relationship: _____Phone: _____Mobile:_____

RISK ISSUES:

Risk Identified	**Past hx** *(tick if present)*	**Current** *(tick if present)*	**Details/ Management**
Deliberate self-harm/suicide			
Violence/aggression			
Sexual assault/abuse			
Substance use/abuse			
Self-neglect			
Other vulnerabilities			

LEGAL STATUS:

Is the Young Person subject to DCF involvement/Mental Health Act/Forensic or other Legal requirement?

_____

PRIMARY REASON FOR REFERRAL:

Mental Health ☐ Early Psychosis ☐ Alcohol/Drug ☐ Vocation/Education ☐ Other/unsure ☐

Is there a Mental Health Care Plan included: Yes / No If Yes - Date created? _____

Please Note: *hYEPP Referrals from Mental Health services require a copy of ALL relevant collateral information (including assessment, discharge summaries, medication history and management/recovery plans) prior to the referral being processed*

PRESENTING ISSUES:

☐ Mood disturbance	☐ Family difficulties	☐ Intellectual Impairment
☐ Anxiety	☐ Relationship issues	☐ Physical illness
☐ Stress	☐ Trauma history	☐ Difficulties with school/work
☐ Difficulty sleeping	☐ Domestic violence	☐ Delusions or odd beliefs
☐ Eating concerns	☐ Bullied/bullying others	☐ Unusual behaviour/speech
☐ Low self esteem	☐ Body image issues	☐ Functional decline

☐ Hallucinations (unexplained auditory, visual or other sensory perceptions)

☐ Drug and alcohol use _____

☐ Other_____

☐ Cultural/Religious customs for treating team to be aware of _____

BRIEF OVERVIEW OF PRESENTING ISSUES:

YOUNG PERSON STRENGTHS:
