CLIENT DETAILS (THESE DETAILS WILL BE USED TO CONTACT THE YOUNG PERSON)

First Name:_____ Surname: _____

D.O.B: _____ Age: _____ Gender: ☐M ☐F ☐Other _____

Address: _____

Suburb: _____ Post Code: _____

Home Phone: _____ Mobile: _____

Email Address: _____

Lives with: _____ Relationship: _____

Preferred Contact Person: _____ Phone: _____

Is the young person aware of the referral and wanting services from headspace Cairns? ☐Y ☐N

REASON FOR REFERRAL

☐ Counselling Services ☐ GP Services ☐ Assessment of Vocational Needs

☐ Alcohol/Drug ☐ Groups ☐ Other _____

REFERRER DETAILS (PERSON COMPLETING THIS DOCUMENT)

Contact Name: _____ Position / Relationship: _____

Organisation (if applicable): _____

Postal Address: _____ Post Code_____

Phone: _____ Fax:_____ Mobile: _____

Email: _____

Preferred Delivery Method of Progress Reports: ☐Fax ☐Post

AUTHORISATION OF REFERRAL BY 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.
I give permission for headspace Cairns to use my contact details above for future contact with me.
I give permission for headspace Cairns staff to obtain further information relevant to this referral.

Signed: _____ Print Name: _____ Date: _____

If the young person is under 18 years of age, consent should be provided by a parent/guardian (if possible and/or appropriate):

Parent/Guardian Signed:_____ Print Name: _____ Date: _____

1. PRESENTING ISSUES

- ☐ ANXIETY
- ☐ REFUSING SCHOOL
- ☐ DEPRESSION
- ☐ SELF HARM
- ☐ HARM/THREATS TO OTHERS
- ☐ STRESS
- ☐ SUICIDAL
- ☐ PENDING LEGAL MATTERS
- ☐ DIFFICULTY SLEEPING
- ☐ DRUG ABUSE
- ☐ ALCOHOL ABUSE
- ☐ PAST/PRESENT CONTACT WITH CHILD SAFETY
- ☐ OTHER _____
- ☐ PAIN MANAGEMENT ISSUES
- ☐ FAMILY PROBLEMS
- ☐ PHYSICAL ABUSE
- ☐ RELATIONSHIP ISSUES
- ☐ LOW SELF ESTEEM
- ☐ DOMESTIC VIOLENCE
- ☐ EMOTIONAL ABUSE
- ☐ HALLUCINATIONS & DELUSIONS
- ☐ EATING PROBLEMS
- ☐ HISTORY OF HOSPITALISATION
- ☐ PRESENTATION TO HOSPITAL
- ☐ ADHD/ADD
- ☐ FINANCIAL DIFFICULTY
- ☐ LOSS OF APPETITE
- ☐ PHYSICAL DISABILITY
- ☐ SEXUAL ABUSE
- ☐ PTSD/TRAUMA HISTORY
- ☐ SOCIAL PROBLEMS
- ☐ ASPERGERS/AUTISM
- ☐ BODY IMAGE
- ☐ BULLYING OTHERS
- ☐ CRYING

2. RISK TO SELF OR OTHERS:

3. OTHER AGENCIES/HEALTH CARE PROVIDERS CURRENTLY INVOLVED IN THE YOUNG PERSONS CARE PRESENTING ISSUES

4. WHAT DO YOU HOPE HEADSPACE CAIRNS CAN ACHIEVE FOR THIS CLIENT

5. SUMMARY OF YOUNG PERSON

Please fax referral form to headspace Cairns 07-4041 6340

Level 2, 42 Grafton Street, Cairns ✉ PO Box 7399, CAIRNS QLD 4870 www.headspace.org.au/cairns

☎ 4041 3780 4041 6340