# Referral to headspace Redcliffe

**On completion of this form, please email to: headspace.Redcliffe@openminds.org.au, or fax to: 07 3897 1800, or post to: PO Box 636, Redcliffe QLD 4020**

headspace Redcliffe
Street 457 Oxley Avenue, Redcliffe QLD 4020
Mail PO Box 636, Redcliffe QLD 4020
Tel 07 3897 1897 Fax 07 3897 1800
headspace.org.au

**Important information regarding your referral, please read:**

- **headspace** Redcliffe is a service for young people between the ages of 12 to 25. We can only engage with young people who have provided consent to the referral.
- If the young person is at high or acute risk of suicide, please contact emergency services on 000.
- Please note that receipt of the referral form does *not* indicate acceptance to the **headspace** Redcliffe services. Suitability of the referral will be determined following assessment with the young person. Please call **headspace** Redcliffe to confirm receipt and discuss the outcome of your referral.
- To complete the referral, you must attach relevant assessment notes, discharge summaries and/or additional information.
- We will endeavour to respond to referrals within 24-48 hours if received during business hours.

**Consent for referral:**

| | | |
|---|---|---|
| Has the young person consented to and provided permission to exchange information in relation to this referral? | ☐ **Yes** | ☐ **No** |

**Primary reason(s) for Referral:** This section must be completed. Please contact us if you have any queries regarding available services.

☐ Short-term Mental Health Intervention with **headspace** Redcliffe Primary Care Team

Does the young person have a Mental Health Care Plan? ☐ Yes ☐ No

| | |
|---|---|
| ☐ Drug and/or Alcohol Support | ☐ Vocational Support |
| ☐ Physical Health Support | ☐ Other, please specify _____ |

**Referrer details: headspace** will be corresponding with you using the below details. Please ensure that all details listed below are correct and legible.

| | | | |
|---|---|---|---|
| Name of Referrer: | | Organisation: | |
| Relationship to Young Person: | | Designation: | |
| Contact Number: | | Fax Number: | |
| Service Address: | | | |
| Email Address: | | | |

Do you wish to be part of our mailing list? ☐ Yes ☐ No

**Parent/guardian:** Please note that if the young person is aged 18 and under, we will require a parent or legal guardian to be documented on this form and attend the first appointment.

| | | | |
|---|---|---|---|
| Name: | | | |
| Relationship to young person: | | Contact Number: | |

Do we have permission to speak with the person identified? ☐ Yes ☐ No

**Young Person's Details:**

Name:

Date of Birth: Age: Gender:

Address:

Suburb: Post code:

Contact Number 1: 2.

Medicare Card Details: Expiry Date:

Interpreter Required? ☐ Yes, Language: ☐ No

Assistance with Reading/Writing? ☐ Yes ☐ No

**Presenting Issues:**

**Current presenting issues (please include duration, age of onset, and relevant pre-existing diagnoses):**

**Impact of problem on functioning:** (e.g. relationships/school/home/work)

**Please indicate if there is any known family history of mental health conditions:**

**Previous/current engagement with other services:** (if current and referrer, assessment information must be attached)

**Risk Factors:**

☐ Suicide ☐ Non-accidental self-injury ☐ Harm to others ☐ Extreme social withdrawal

☐ Homelessness ☐ Substance use ☐ Accidental Death ☐ Non-compliance

**Please provide details:**

Referrer's Signature:

*By signing this document, the referrer agrees that the above information is a true and accurate record.*

Date:

**OFFICE USE ONLY**

***When booking appointment, please request that the YP attends 15 minutes prior to their appointment time***

☐ Book with Intake Clinician Date/Time: Clinician:

☐ Declined/Referred Elsewhere Recommendations Made: