Referral to headspace Brookvale

Please ensure all sections are completed and legible.

*Return via **email**: info@headspacebrookvale.org.au,*

***Post**: Level 2 Brookvale House, 1a Cross Street, Brookvale NSW 2100 or **Fax**: 02 9938 3099 **Tel**: 9937 6500*

headspace Brookvale Referral Criteria

headspace Brookvale is a service for young people between the ages of 12 and 25.

headspace Brookvale can only engage with young people if they have consented to the referral voluntarily.

Has the young person consented to and provided permission for a referral (Y/N)? .....

Is the Young Person aged between 12 - 25? (Y/N) .....

Core area(s) of support needed (Y/N): .....

Mental Health .....

Physical and Sexual Health .....

headspace Brookvale is not a crisis service. We are unable to support severe Mental Health concerns or crisis referrals. Please call 000 for emergencies or the Mental Health Line on 1800 011 511 if you have concerns.

Young Person's Details

Name: .....

Date of Birth: ..... Age: ..... Gender: .....

Address: .....

Suburb: ..... Post code: .....

Contact Number: Home ..... Mobile .....

Cultural Identity: ..... Language Spoken at home: .....

Preferred language: ..... Interpreter needed (Y/N): .....

Indigenous Identity: Aboriginal ..... Torres Strait Islander ..... Both ..... Neither .....

Medicare Number ..... Position Number on Card ..... Exp Date: .....

Parent/Guardian *please note that if the Young person is under 16 years of age, we will require a parent or guardian to be documented on this form*

Name: .....

Relationship to young person: ..... Contact Number: .....

Do we have permission to speak with the person identified (Y/N)?

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

Name of Referrer: ..... Organisation: .....

Relationship to Young Person ..... Designation: .....

Contact Number ..... Fax: .....

Service Address .....

Email .....

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Primary reason(s) for Referral: This section must be completed and/or assessment notes attached

Include information here

Presenting Issues:

Please include any specific information regarding presenting issues and/or support requests

Does the young person have a mental health care plan? (write Y/N):

Date and issuing doctor (if known):

Does the young person have a pre-existing diagnosis by a mental health clinician?
(Write Y/N and state diagnosis):

If so, please provide details of diagnosis. Please include relevant information only, including: diagnosis; details of diagnosis; details of health professional providing diagnosis

Is the young person currently, or have they previously accessed any specific mental health or general support services?

Referrer's Signature

(Write or Digital or Name):

Date: