**Referral Form**

Email to: [headspaceliverpool@benevolent.org.au](mailto:headspaceliverpool@benevolent.org.au) or

Fax referral to: 02 8568 7932

* We strongly recommend anyone making a referral to also **call and speak to the intake worker** on 1800 026 517. Our opening hours are 8.30am to 5.00pm, Monday to Friday.
* Referrals are generally considered on the Monday after we receive them. We’ll be in touch after that to offer an appointment or to discuss who might be in a better position to support the young person (YP).
* **We are not an emergency service**. If the YP needs immediate assistance, please call the mental health care line (1800 011 511) or go to the nearest hospital emergency department.

**Date:**

**Who is making the referral?**  Self  Service provider  Family/friend  Walk-in

**Does the YP know about this referral?** Yes

*If not, the referral cannot be accepted. Get in touch and we’ll talk you through some other options.*

**Is the YP between 12 and 25 years of age?** Yes

**If under 16 years, are the parents/carers aware?** Yes

|  |  |  |  |
| --- | --- | --- | --- |
| *Name* |  | | |
| *Date of Birth* |  | | |
| *Gender* |  | | |
| *Address* |  | | |
| *Who with?* | At home with family Living alone  Staying with friends  Homeless  Refuge  supported accommodation | | |
| *YP Phone Number* |  | | |
| *Email (optional)* |  | | |
| *Name of parent/guardian (optional)* |  | *Relationship to YP* |  |

**Is YP at school, TAFE, university or working?** Yes  No

|  |  |
| --- | --- |
| *Where?* | *Year / Level?* |

**What cultural background does the YP identify as?**

**Does YP need an interpreter?** Yes  No

**If ‘Yes’, what language?**

**Is YP from a refugee background?** Yes  No

**Is YP of Aboriginal or Torres Strait Islander background?** Yes  No

**Are any of these issues for the YP at the moment?**

Physical health  Sexual health  Body image  Alcohol or drugs

Other:

|  |
| --- |
| 1. What’s lead to referring to headspace? What are the current concerns? |
| 1. Is the YP at risk of harming themselves or others? Are there any identifiable risk factors? (e.g. thoughts of suicide, self-harm, risk-taking behaviours, harming others) |
| 1. Anything else happening that might be affecting the YP? (e.g. family issues, exam stress, issues with friends or relationships) |
| 1. Any previous mental health support / treatment, counselling, medication or diagnoses? |
| 1. What does the YP feel would be useful about coming to headspace? How motivated are they to come? |
| 1. Any other information that may be relevant? (e.g. family history of mental health issues, court involvement, intellectual disability, physical disability) |

**Referrer details (if appropriate)**

|  |  |
| --- | --- |
| *Name* | *Position / Organisation* |
| *Best contact number* | *Email* |
| *Fax* | *Address* |

**Who is the best person to contact about this referral?**  YP

Parent / Guardian

Referrer

**Does YP have a GP?**  Yes  No

|  |  |
| --- | --- |
| *GP Name* | *Medical Centre / Practice* |

**Is there a current Mental Health Treatment Plan?** Yes  No

**Any other workers/services involved?**

|  |  |
| --- | --- |
| *Name* | *Position / Organisation / Contact number* |