**Eligibility Criteria:**

* General Practitioners are able to fax/email a Mental Health Care Plan to headspace Nundah instead of completing this referral form.
* **Referral from Service Providers** **will require a copy of ALL relevant collateral information** *(including any assessments, discharge summaries & recovery documents)* **prior to the referral being triaged.**
* **headspace** Nundah works **under Medicare Benefit Schedule (MBS)**, this means clients are only **eligible up to 10 Sessions** with Private Practitioners (Psychologists and Clinical Psychologists). We also have a Psychiatrist and Dietitian on site, which can be accessed if deemed appropriate by the Intake Team.
* Referrals from **Probation and Parole** require social history, information on convictions and pending legal matters including dates, **prior to referral being triaged**.

1. **Referrer (Individual completing this document)**

**Contact Name:** Click here to enter text.

**Position / Relationship:** Click here to enter text.

**Organisation (if applicable):** Click here to enter text.

**Postal Address:**  Click here to enter text. **Post Code:** Click here to enter text.

**Phone:** Click here to enter text. **Mobile:** ­ Click here to enter text. **Fax:** Click here to enter text.

**Email:** Click here to enter text.

1. **Young Person Being Referred (these details will be used to contact the young person /parent, guardian)**

**First Name:** Click here to enter text. **Surname:** Click here to enter text.

**Date of Birth:** Click here to enter text. **Age:** Click here to enter text. **Gender:**  **M**   **F**  **Other**

**Address:** Click here to enter text.

**Suburb:** Click here to enter text. **Postcode:** Click here to enter text. **State:** Click here to enter text.

**Home Ph**: Click here to enter text. **Mobile:** Click here to enter text.

**If consent provided by the young person (under 16), please provide details of their parent/ guardian:**   
Click here to enter text.

***Note To Referrer***

**Please provide as much information as possible as it ensures the best quality of care, outcome and if required referral is afforded to the young person being referred.**

**If the young person is experiencing high levels of distress which may result in harm to themselves or others, please refer them directly to your local Emergency Department or a GP for immediate assistance as headspace is not a Crisis Service or equipped to manage these types of emergencies.**

1. **Reason For Referral:**

**Physical Health**  **Mental health**  **Alcohol/Drug**  **Vocational**   **Assessment**

**Other - please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Information About The Young Person**

**(If Applicable) Risk to self or others (Include self-harm/ suicide attempts, violence, threats of violence)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Type of Behavior** | **Reason for Behavior** | **Outcome/ Treatment Provided** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

(If Applicable) Other Agencies / health care providers currently involved within the individuals care: (e.g.: Government, non Government, GP’s, Psychiatrists, and Community Services)

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Organisation** | **Contact Person** | **Address** | **Phone** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

1. Presenting Issues

Anxiety  Pain Management Issues  Adhd / Add  Refusing School

Family Problems  Financial Difficulty  Difficulty sleeping  Depression

Physical Abuse  Loss of Appetite  Eating Problems  Self Harm

Relationship Issues  Physical disability  Drug Abuse  History of hospitalisation

Harm or threats to others  Sexual Abuse  Intellectually Impaired  Stress

Domestic Violence  Ptsd / Trauma History  Body Image  Suicidal

Emotional Abuse  Social Problems at School  Bullying Others  Pending Legal Matters

Presentation to ED or Hospital Hallucinations and delusions  Crying  Aspergers / Autism

Past or present contact with Child Safety  Other Click here to enter text.

**Do you have any final comments or relevant information?**

Click here to enter text.

1. **Consent Of Young 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.  Please NOTE: Referrals will not be processed without signed consent. | |
| I give permission for **headspace** Nundah to use my contact details above for future contact with me. | Yes  No |
| I give permission for the **staff** of **headspace** Nundah to obtain relevant information from government and non-government agencies, from doctors and other health professionals specifically relevant to my care whilst being a client of **headspace** Nundah. | Yes  No |
| I give permission for **headspace** Nundah to contact the referrer and advise once an appointment has been arranged. | Yes  No |

**Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Print Name:** Click here to enter text. **Date:** Click here to enter text.

***If under 18 years of age authorisation ideally should be provided by a parent/ guardian.***

**Parent/ Guardian Signed:** **Print Name:** Click here to enter text.**Relationship:** Click here to enter text.

1. thank you for your referral

**Please return this form to headspace Nundah**

PO Box 263, Nundah, QLD 4012

1264 Sandgate Rd, Nundah

Ph 07 3370 3900

Fax 07 3370 3999

Email [Headspace.Nundah@aftercare.com.au](mailto:Headspace.Nundah@aftercare.com.au)

1. What Next?

* On receipt of a referral form **headspace** Nundah will contact the service provider to advise of the outcome and then if applicable contact the young person to arrange an appointment.
* All initial appointments will be with a **headspace** Nundah Intake Clinician, this process takes between 1 – 2 hours.