



## Referral to headspace Services

(Please select ONE and forward to nearest centre)

<p style="text-align: center;"><input type="checkbox"/> <b>Mt Druitt</b></p> <p>Shop 12, Daniel Thomas Plaza 6-10 Mount St, Mt Druitt NSW 2770 <b>Phone:</b> (02) 9675 2602 <b>Fax:</b> (02) 8887 5610 <b>Email:</b> <a href="mailto:headspacemtduitt@ucmh.org.au">headspacemtduitt@ucmh.org.au</a></p>	<p style="text-align: center;"><input type="checkbox"/> <b>Parramatta</b></p> <p>2 Wentworth St, Parramatta NSW 2150 <b>Phone:</b> (02) 8624 1348 <b>Fax:</b> (02) 8624 1388 <b>Email:</b> <a href="mailto:headspaceparramatta@ucmh.org.au">headspaceparramatta@ucmh.org.au</a></p>	<p style="text-align: center;"><input type="checkbox"/> <b>Penrith</b></p> <p>606 High St, Penrith NSW 2750 <b>Phone:</b> (02) 4720 8888 <b>Fax:</b> (02) 4720 8844 <b>Email:</b> <a href="mailto:headspacepenrith@ucmh.org.au">headspacepenrith@ucmh.org.au</a></p>
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**Important information regarding your referral, please read:**

- headspace** 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. *N.B. If YP is unable to provide informed consent due to mental state (e.g. psychosis), please contact us.*
- 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** services. Suitability of the referral will be determined following assessment with the young person. Please contact the relevant **headspace** site 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. If you have any queries pertaining to your referral, please phone the relevant site using the contact details above.

**Consent for referral:** *If YP is unable to provide informed consent due to mental state (e.g. psychosis), please contact us.*

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 for queries regarding services available

<input type="checkbox"/>	Assessment for short-term mental health intervention with <b>headspace</b> Primary Care Team		
	Does the YP have a Mental Health Care Plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/>	Assessment with <b>headspace</b> Youth Early Psychosis Program (YEPP)		
<input type="checkbox"/>	Drug and Alcohol Support	<input type="checkbox"/>	Vocational Support
<input type="checkbox"/>	Physical Health Support		

**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:	<input style="width: 95%;" type="text"/>	Organisation:	<input style="width: 95%;" type="text"/>
Relationship to Young Person	<input style="width: 95%;" type="text"/>	Designation:	<input style="width: 95%;" type="text"/>
Contact Number	<input style="width: 95%;" type="text"/>	Fax:	<input style="width: 95%;" type="text"/>
Service Address:	<input style="width: 95%;" type="text"/>		
Email:	<input style="width: 95%;" type="text"/>		
Do you wish to be part of our mailing list?		<input type="checkbox"/> Yes	<input type="checkbox"/> No



**Parent/guardian:** \* please note that if the Young person is aged 15 and under, 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?  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 know family history of mental health conditions:**



**Previous/current engagement with other services:**

Four horizontal text input fields for recording previous or current engagement with other services.

**Risk Factors:**

- Suicide
- Non-accidental self-injury
- Harm to others
- Extreme social withdrawal
- Homelessness
- Substance use
- Accidental Death
- Non-compliance

**Details:**

Four horizontal text input fields for providing details of the risk factors.

Referrer's Signature:

Text input field for the referrer's signature.

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

Date:

Text input field for the date.

**Office Use Only**

**Plan (to be reviewed at intake meeting):** *When booking appointment, please request that the YP attends 15 minutes prior to their appointment time*

- Book with YAT Clinician      Date/Time: \_\_\_\_\_ Clinician: \_\_\_\_\_
- Joint YAT/MATT Consultation      Date/Time: \_\_\_\_\_ Clinician: \_\_\_\_\_
- Direct Allocation to CCT      Date/Time: \_\_\_\_\_ Clinician: \_\_\_\_\_
- MATT Assessment
- Referral to Co-located LHD Team      Date/Time: \_\_\_\_\_ Clinician(s): \_\_\_\_\_
- Declined/Referred Elsewhere      Recommendations Made: \_\_\_\_\_