**STOP**!!!!   
professional referrer please use ‘professional referral form’ Thanks

**Do you believe this young person is at risk of harm to themselves or other people?**  Yes  No  
headspace is an early intervention and prevention service. If the young person is at risk of harm to themselves or to someone else, they are no suitable for headspace services. Please contact the mental health hotline on 1800 011 511 (24 hours) for appropriate services, take them to your nearest hospital, or call 000.

|  |  |  |
| --- | --- | --- |
| **Today’s date:** |  | |
| **Your Name:** |  | |
| **Relationship to Young Person (YP):** |  | |
| **Your Phone number:** |  | |
| **Your Email Address:**  **Can we send you emails/some resources?**  Yes No |  | |
| **Does your young person know you are contacting us today?** Yes No | | If no, **STOP**…  Family/Friends can make an appt on behalf of a YP, **only** if the YP consents to the appt.  Please consider the following options. |
| **Options 1:** Get consent from your young person to make the appointment. Then continue with referral form.  **Options 2:** If you need support on how to chat with your young person and encourage them to attending headspace:  - Please do not fill in any more of this form   - let us know and we can provide you guidance | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Young person’s name (preferred):** |  | | |
| **Age:** |  | **DoB:** |  |
| **Gender:** |  | **Pronouns:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Does the Young Person identify as:** | Aboriginal  Torres Strait Islander  Both  Non-Indigenous  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Language other than English spoken at home:** |  | **Interpreter needed?** |  |

|  |  |
| --- | --- |
| **Young Person Address:**  **Can we send mail to this address?**  Yes No |  |
| **Young Person email**:  **Can we send emails?**  Yes No |  |
| **Young Person mobile number:**  **Can we call and/or text this number?**  Yes No |  |
| **When is the best time for us to contact the Young Person about this referral?** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **sessions usually take between 45-50 minutes. appointments with our doctor are usually 30-45 minutes** | | | |
| **What services do you think your young person would benefit from?** | | | |
| Mental health wellbeing | Alcohol & another drug support | Physical and/or sexual health support | Work and Study support |
| **(Yes/No/Unsure)** | **(Yes/No/Unsure)** | **(Yes/No/Unsure)** | **(Yes/No/Unsure)** |

|  |  |
| --- | --- |
| **What do you hope headspace Lithgow can support your young person with?**  **What do you feel would be useful about your young person coming to headspace?** |  |

**Office Use Only……**

|  |  |
| --- | --- |
| **Notes:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Appt date:** | **Appt time:** | **Appt type:**(person/phone/telehealth) | **Who will be attending appt:**  (eg family/friend) | **Clinician:** |
|  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Informed of headspace Location:** | ☐Yes   ☐No | **Ask to arrive 10 mins early:** | ☐ Yes   ☐ No |

|  |  |
| --- | --- |
| SRI? ☐ Yes ☐ No | YP created on HAPI ☐ Complete |
| File named on Mastercare as SRI: ☐ Complete | Create an OoS for 1st contact ​☐​ Complete |
| Notify clinical team: ☐ Yes ☐ No | Client created on MC ​☐​ Complete |
| Intake booked into diary ​☐​ Complete | Welcome email sent to YP & added to MC ​☐​ Complete |