Date:

headspace Batemans Bay Community Referral Form

GPs to complete Mental Health Treatment Plans (MHTP)

All inquiries, contact **1800 718 383** between the hours of 9am – 5pm Mon, Tues, Wed, Fri, and 10am - 6pm Thurs. Please fax referrals to headspace Batemans Bay **02 9169 3478**

Important Information About Your Referral

headspace is a service for young people aged 12-25. We can only engage with young people who have provided consent to this referral.

headspace Batemans Bay will be offering services to young people to support their mental health, physical health, any alcohol and or other drug related issues, and provide support for work and study.

This service is BULK BILLED THROUGH MEDICARE and we will need a Medicare number to provide services.

headspace Batemans Bay is not a crisis service and should you have any concerns, if the young person is in crisis, or if they are at an acute risk of harming themselves or others, please contact emergency services on **000**. In a mental health emergency please contact Mental Health Line on **1800 011 511**

The receipt of this referral form does **not** indicate acceptance to headspace Batemans Bay. Suitability of the referral will be determined following assessment with the young person. Please contact us on 1800 718 383 (between 9am - 5pm, Mon, Tues, Wed, Fri, and 10am - 6pm Thurs) to confirm receipt and discuss the outcome of your referral.

To provide a complete referral, please attach any relevant assessment notes, discharge summaries and/or additional information (eg MHTP). We will endeavour to respond to referrals within 48 business hours, but if you have any queries, please phone us on the contact details above.

Young Person's Details *(Red fields are required)*

Name: _____ **DOB:** _____

Full name

Address: _____

Address *(Postal Address if different)*

Is it okay for us to send headspace branded documents to this address? YES ☐ NO ☐

Phone: _____ **Email:** _____ Gender: _____ Preferred pronouns: _____

Medicare No: _____ **Position on card:** _____ Exp. _____

Next of Kin/Emergency Contact: _____

(Please include relationship to young person and contact phone number)

Does the young person require an interpreter? YES ☐ NO ☐ If yes, which language?

Does the young person identify as Aboriginal? Yes ☐ No ☐

Does the young person identify as Torres Strait Islander? Yes ☐ No ☐

Does the young person identify as Aboriginal AND Torres Strait Islander? Yes ☐ No ☐

Does the young person have a GP? YES ☐ NO ☐ Does the young person have a MHTP? Yes ☐ No ☐

Practice Name *(if applicable)*: Doctor's Name *(if applicable)*:

Consent

Does the young person consent to this referral? Yes ☐ No ☐

Does the young person consent to sharing information with the headspace Batemans Bay team? Yes ☐ No ☐

headspace Batemans Bay offers early intervention, short term support for young people experiencing mild to moderate mental health difficulties.

Reason for Referral

What are some of the current issues? (*please include info about duration, age of onset and pre-existing diagnoses):*

What has been the impact of these? *(eg relationships, school, work, home etc)*

What are the young person's goals and objectives?

Is there any family history of mental health conditions?

Is the young person currently supported by other health services? *(If so, please provide service details below)* YES ☐ NO ☐

Does the young person consent to headspace Batemans Bay exchanging information with these services to support this referral?

Yes ☐ No ☐

Risk Factors *(referrer to complete all risks if known)*

Suicide	**None**	☐	**Low**	☐	**Medium**	☐	**High** ☐
Non-suicidal self-injury	**None**	☐	**Low**	☐	**Medium**	☐	**High** ☐
Harm to others	**None**	☐	**Low**	☐	**Medium**	☐	**High** ☐
Vulnerability	**None**	☐	**Low**	☐	**Medium**	☐	**High** ☐

Other risk factors?
eg homelessness, social withdrawal, medication compliance

Referrer's Details

Name: _____ Phone: _____

Email: _____

Organisation (if applicable): _____

Relationship to young person: _____

Office Use Only_____

Preferred appt method: Video ☐ Phone ☐ Appt bkd Date: _____ Time: _____

Referred elsewhere (details): _____ Person completing this form: _____