**Referral Form**

**SERVICE REQUIRED (PLEASE INDICATE BELOW WHICH SERVICE YOU ARE REFERRING TO)**

**headspace Caboolture headspace Kilcoy headspace Bribie Island**

**ELIGIBILITY**

**headspace** Caboolture is an early intervention service for young people aged 12-25 with mild to moderate mental health concerns.

* Referrals from QLD Health require a copy of ALL relevant collateral information (including assessment, discharge summaries, & recovery documents) prior to the referral being processed.
* Referrals from Child Safety require a copy of ALL relevant collateral information (including assessment, care arrangements, & court orders) prior to the referral being processed.
* Referrals from Youth Justice or Probation and Parole require a copy of ALL relevant collateral information (particularly regarding risks), along with AOD information prior to referral being processed.

**REFERRER (INDIVIDUAL COMPLETING THIS DOCUMENT)**

Contact Name:

Position / Relationship:

Organisation (if applicable):

Postal Address: Post Code:

Phone: Mobile:

Fax: Email:

Signed:

**PRIMARY REASON(S) FOR REFERRAL**

Mental health Alcohol/Drug Physical Vocational Other

**PERSON BEING REFERRED (THESE DETAILS WILL BE USED TO CONTACT THE YOUNG PERSON/CARER, GUARDIAN)**

FIRST NAME: SURNAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: Age: Gender:

Address:

Suburb: Postcode: State:

Home Ph: Mobile:

If consent provided by young person please provide details of their parent/ guardian:

**AUTHORISATION OF REFERRAL BY PERSON BEING REFERRED**

**Please NOTE: Referrals will not be processed without signed consent.**

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.

I give permission for **headspace** Caboolture to use my above details to contact me in future. Yes No

I give permission for the staff of **headspace** Caboolture 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** Caboolture.

Signed: Print Name: Date:

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

Carer/Guardian Signed: Print Name: Relationship:

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Type of Behaviour** | **Reason for Behaviour** | **Outcome/ Treatment Provided** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Other Agencies/health care providers currently involved with the young person’s care: (e.g., Government, non-Government, GP’s, Psychiatrists, and Community Services)

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Organisation** | **Contact Person** | **Address** | **Phone** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

PRESENTING ISSUES

Anxiety Pain Management Issues ADHD/ADD

Refusing School Family Problems Financial Difficulty

Depression Physical Abuse Loss of Appetite

Self-Harm Relationship Issues Physical disability

Harm or threats to others Sexual Abuse Intellectually Impaired

Stress Domestic Violence PTSD/Trauma History

Suicidal Emotional Abuse Social Problems at School

Crying Hallucinations and delusions Asperger’s/Autism

Difficulty sleeping Eating Problems History of hospitalisation

Drug Abuse Body Image Presentation to ED or Hospital

Alcohol Abuse Bullying Others Past or present contact with CS

Low Self Esteem Pending Legal Matters Functional decline

Other

Please **fax**/**email** Referral Form to **headspace** Caboolture Access & Intake Team

Fax (07) 5499 4355 or email [hsCReception@unitedsynergies.com.au](mailto:hsCReception@unitedsynergies.com.au)