headspace Lithgow Referral Form

Once completed please email to: hs.Lithgow@marathonhealth.com.au



Do you believe this young person is at risk of harm to themselves or other people? \square Yes \square 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.

Client informatio	n				
Young per:	sons preferred name:				
Your	ng persons last name:				
Are they known	by any other names:				
date of birth:			age:		
gender:			pronouns:		
Indigenous/Cult	ural Identity: 🔲 Aborig	inal 🛘 Torres Strait Isla	nder 🗆 Both	☐ Non-Indigenous	
Residential address: Suburb: Postcode:					
Who with?	\square At home with family	☐ Living alone	☐ Hom	ieless	
	☐ Staying with friends	☐ supported accommo	dation 🗆 Refu	ge	
Phone number:		Email (optional):			
If the young pers	son is under 16 does the p	parent/guardian consent	to this referral?	☐ yes ☐ no	
	Name of parent/g				
	Parent/guardian contact	number:			
Additional details	S				
	Does YP ha	ve a GP?			
		rs name:			
Medical centre / Practice:					
Is there a current Mental Health Treatment Plan? ☐ yes ☐ no					
	young person have an NI	`			
Any	other workers/services in				
Name:					
Position:					
	Organisation / Contact	number:			
Referrers details.					
	Name:				
Position / Orga					
Deal and a	Email:				
Best contact					
	Address:				
Best person to	contact about this referra	ll:	Parent/Guardian	☐ Referrer	
Reason(s) for refe	erral				
What's lead to referring to headspace? What are the current concerns?					

Are there any identifiable risk f	factors? (e.g. thoughts of suicide, self-harm, risk-tak	ing behaviours, harming				
others)						
Has anything else happening th	nat might be affecting the young person? (e.g. family	y issues, exam stress,				
issues with friends or relationships)						
Anything from the past that might be affecting the young person now?						
	<u> </u>					
Any provious montal health su	nnort/treatment_councelling_medication or diagno	cor?				
Any previous mental health support/treatment, counselling, medication or diagnoses?						
What does the young person feel would be useful about coming to headspace? How motivated are they to						
come?						
Any other information that may be relevant? (e.g. family history of mental health issues, court involvement,						
<u>disability)</u>						
Consent	. 1916					
	e Lithgow to accept this referral: ged between 12 and 25 years of age					
 The young person consents to this referral We require consent of the young person or parent/guardian if under the age of 16. 						
• We require consent of the young person of parent/guardian if under the age of 10.						
If this is not possible, please get in touch and we'll talk you through some other options.						
	am aware of and consent to this referral being mad					
I understand t	hat I can withdraw from this referral or from the ser	vice at any time.				
Client name	Client signature	Date				
Chefit hame	Client signature	Date				
Parent/Guardian name	Parent/Guardian signature	Date				
r arenty Guardian name	i arenty duartian signature	Date				
Referrer name	Referrer signature	Date				
	3					