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| **What does headspace do?**  headspace Midland is a *Youth Mental Health service for young people aged 12-25* experiencing mild to moderate mental health difficulties (also known as a Tier 2 service). We offer a variety of support options and can also assist young people with referrals to other services within their community.  **What happens after a referral is submitted?**  If the young person is better suited to an alternative support option, headspace Midland will notify the referring agency with the recommendations.  If headspace Midland is unable to contact the young person, we will notify the referring agency. | | | | | | | | | | | | | | | | |
| **Prior to Completing the Referral** | | | | | | | | | | | | | | | | |
| ***Please tick to acknowledge that you have read the following points prior to completing the referral.***  Young person is aware and consenting to the referral.  Young person is experiencing mild to moderate mental health difficulties.  We are a multidisciplinary team and do not accommodate discipline specific requests (e.g., requests for clinical psychologist).  We do **not** provide psychiatry. *Psychiatry and individual outreach are available through our headspace Early Psychosis Service,* [*click here for more information*](https://headspace.org.au/headspace-centres/midland/) *or contact them at 9301 8999.*  We are **not** a crisis service. We aim to attempt to contact the young person within 3 business days of receiving a referral. If an appointment is offered, we endeavour for the young person to be seen within 2-4 weeks. *(Please note wait times vary and are subject to service demand).*  ***If you are unsure if headspace is the best support option for a particular young person, please contact our triage officer on 9274 8860 to discuss support options.*** | | | | | | | | | | | | | | | | |
| **Young Person’s Details** | | | | | | | | | **Referral Date:** Click or tap to enter a date. | | | | | | | | |
| **Legal Name:** | | | | Click or tap here to enter text. | | | | **Preferred Name:** | | | | | | Click or tap here to enter text. | | | |
| **Date of Birth:** | | | | | Click or tap to enter a date. | | | **Pronouns:** | | | | Click or tap here to enter text. | | | | | |
| **Sex:** | Click or tap here to enter text. | | | | | | | **Gender:** | | | Click or tap here to enter text. | | | | | | |
| **Phone:** | | Click or tap here to enter text. | | | | | | **Email:** | | Click or tap here to enter text. | | | | | | | |
| **Address:** | | | Click or tap here to enter text. | | | | | | | | | | | | | | |
| **Medicare:** | | | Card Number: | | | | Click or tap here to enter text. | | | | Index: | |  | | Expiry: | / | |
| **Does young person identify within the LGBTQIA+ community** (Lesbian / Gay / Bisexual / Transgender / Queer or Questioning / Intersex / Asexual/ Other)**?**  No  Yes  Unknown | | | | | | | | | | | | | | | | | |
| **Cultural Identity:** | | | | | | Aboriginal  Torres Strait Islander  Both  Neither | | | | | | | | | | | |
| Another Culture: Click or tap here to enter text. | | | | | | | | | | | | | | | | | |

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| **Young Person’s Consent** | | | | | | | | | | | | | | | |
| **Is the young person aware and consenting to this referral being made?**  *(headspace requires the young person’s consent, the referral will not proceed without consent)* | | | | | | | | | | | | | Yes  No | |
|  | | | | | | | | | | | | |  | |
| **Emergency Contact / Next of Kin / Guardian Details** | | | | | | | | | | | | | | | |
| **Name:** | Click or tap here to enter text. | | | | | | | **Relationship:** | | | Click or tap here to enter text. | | |
| **Phone Number:** | | | | Click or tap here to enter text. | | | | |
| **Does the young person live with this person?** | | | | | | | | | | | | | Yes  No |
| **Can this person schedule/cancel appointments?** | | | | | | | | | | | | | Yes  No |
| **Is this person aware that the young person is accessing headspace Midland?** | | | | | | | | | | | | | Yes  No |
| *(If the young person is under the age of 16, parent/guardian consent may be required)* | | | | | | | | | | | | |  |
| **Referrer Details** | | | | | | | | | | | | | | | |
| **Referral Source:** | | | | | | Young Person  Family / Friend  Agency  GP  Other | | | | | | | |
| **Name:** | | Click or tap here to enter text. | | | | | **Phone Number:** | | | | | Click or tap here to enter text. | |
| **Organisation:** | | | Click or tap here to enter text. | | | | | | | **Email:** | | Click or tap here to enter text. | |
| **Is young person currently admitted to hospital?** | | | | | | | | | | | | | Yes  No |
| If *Yes*, when is their estimated discharge date? Please consider phoning triage to discuss suitability of referral prior to completing. EDD: Click or tap to enter a date. | | | | | | | | | | | | | |
| **Is young person receiving support from another mental health service?** | | | | | | | | | | | | | Yes  No |
| *Name of Service:* | | | | | Click or tap here to enter text. | | | | | | | |
| **Have you referred young person to any other service?** | | | | | | | | | | | | | Yes  No |
| *Name of Service:* | | | | | Click or tap here to enter text. | | | | | | | |

*\*Please note psychiatry at headspace Midland is only available for young people accessing the headspace Early Psychosis Service.* [*Click here for more information*](https://headspace.org.au/headspace-centres/midland/)*.*

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| **Presenting Concerns** | | | | |
| Mental health | Situational | Social support |
| Physical health | Home or environment | Friendships |
| Sexual health | Family support | Relationships / Sexuality |
| Alcohol and drugs | Eating | Vocational / Educational |
| **Please elaborate (include duration):**  Click or tap here to enter text. | | | |
|  | | | |
| **Relevant Background Information** | | | |
|  | | | |
| **Previous mental health diagnosis/treatments and other relevant background information:** (diagnosing or treating practitioner, dates, interventions, medications  Click or tap here to enter text. | | | |
|  | | | |
| **Other relevant information:** (physical health concerns, developmental or learning disabilities, family history)  Click or tap here to enter text. | | | |
|  | | | |
| **Supporting Documentation** | | | |

**Please forward any available relevant documentation.**

|  |  |
| --- | --- |
| **Attached:** | Referral Letter  Discharge Summary  Mental Health Care Plan  Other |

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| **Risk Concerns** |
| Please select all that indicate any known risk concerns: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Risk** | **Current**  (within past month) | **Recent**  (within 6 months) | **Historical** (6 months +) |
| Non-suicidal self-injury |  |  |  |
| Suicide ideation |  |  |  |
| Suicide attempt |  |  |  |
| Substance use |  |  |  |
| Risk of harm *to* others |  |  |  |
| Risk of harm *from* others |  |  |  |
| Homelessness |  |  |  |
| Psychosis/mania |  |  |  |

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| --- |
| **Please elaborate if current:**  Click or tap here to enter text. |

**Once completed, please forward this form and all supporting documentation to headspace Midland via fax (08) 9274 8859 or email** [**reception@headspacemidland.com.au**](mailto:reception@headspacemidland.com.au)**.**

Please note that **headspace** **Midland** does not provide crisis or acute care mental health services.

For mental health emergencies contact the Mental Health Emergency Response Line on 1300 555 788.

We are unable to provide psychological assessments or reports for another purpose (e.g., in relation to Workers Compensation, Centrelink or Court matters). For further information, please contact **headspace** **Midland** by calling (08) 9274 8860 or emailing reception@headspacemidland.com.au.