

**headspace Parramatta  
Service Provider Referral Form**

Please ensure all sections are completed and legible.

Return via email [headspace.parramatta@flourishaustralia.org.au](mailto:headspace.parramatta@flourishaustralia.org.au) or fax: **(02) 8331 6056**

Once a referral form has been received, a Youth Access Team Clinician will make contact with you within 3 working days. Please note that receipt of the referral does not indicate acceptance to the headspace service. The suitability of the referral will be determined following review by our team. Please call to ensure your referral has been received and to discuss anything further. We are happy for you to make contact and discuss service options as sometimes our services are not always the best option for a young person or family. If you have any queries about your referral, please contact us on **1300 737 616**.

**headspace Referral Criteria:**

headspace is a voluntary service for young people aged between 12 and 25. We can only connect with Young People if they have consented to the referral and are in this age group.

**Is the Young Person aged 12 to 25?** Yes  No

**Has the Young Person consented to this referral?** Yes  No

**If under 16 years, is a parent/guardian aware of the referral?** Yes  No

***These are some of the considerations to determine suitability for a referral:***

- Young Person is presenting with mild to moderate symptoms
- Seeking early intervention support
- Requires approximately 12 months of treatment
- Is not at immediate risk of harm to self or others

**If a Young Person requires urgent assistance please note:**

headspace Parramatta is NOT an acute mental health service.

We are unable to support severe mental health concerns or crisis referrals.

We suggest you please call the Mental Health Line on 1800 011 511 if the Young Person requires urgent mental health assistance. Alternatively, direct the Young Person to the Emergency Department of their nearest hospital or call 000.

***Please complete this form with as much information as possible and provide any supporting clinical documentation available as this will assist our team in our assessment and determining suitability. If the referral does not have adequate information, please be aware that we may need to contact you for further information prior to proceeding with the referral.***

We are constantly working on improving our service to young people and would appreciate your feedback. We'd love to hear about your experience through our quick survey:

**<https://www.surveymonkey.com/r/P2JF8YH>**

**1. YOUNG PERSON'S DETAILS:**

Name: \_\_\_\_\_  
 Gender: \_\_\_\_\_ Preferred Pronoun(s): \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Contact Number: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Suburb: \_\_\_\_\_ Postcode: \_\_\_\_\_  
 Cultural Identity: \_\_\_\_\_ Language Spoken at home: \_\_\_\_\_  
 Indigenous Identity: Aboriginal  Torres Strait Islander  Both  Neither   
 Preferred Language: \_\_\_\_\_ Interpreter needed: Yes  No   
 Medicare Card Number: \_\_\_\_\_ Reference Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

**2. PARENT/GUARDIAN/CARER: \***

Name: \_\_\_\_\_  
 Relationship to Young Person: \_\_\_\_\_  
 Contact Number: \_\_\_\_\_  
 Do we have permission to speak the person identified? Yes  No

**\*\* If the young person is aged 15 and under, we will require a parent or guardian**

**3. REASON(S) FOR REFERRAL:**

This section **must** be completed.  
 Please attach any relevant assessment notes, discharge summaries, and/or information.

**Primary reason(s) for Referral:**

Mental Health Support: Brief 1-3 sessions  Focused Psychological Intervention   
 Alcohol and Other Drug Support  Physical Health Support   
 Vocation or Education Support  Groups

**Current Presenting Issues:**

**Please provide details of any diagnoses and treatment:**

Does the Young Person have any pre-existing diagnoses? Yes  No   
 Has the Young Person received previous treatment? Yes  No   
 Does the Young Person have a Mental Health Care Plan (MHCP)? Yes \* No

*If Yes, please attach the referral letter and MHCP*

**\* Please provide details of diagnoses and previous intervention:**

  
  
  
  
  
  
  
  
  
  

**4. SAFETY CONSIDERATIONS**

**Suicidal?** Yes \* No  \* Thoughts  Plan  Intent

Details: \_\_\_\_\_

**Harming self?** Yes  No

Details: \_\_\_\_\_

**Past physical or verbal aggression?** Yes  No

Details: \_\_\_\_\_

**Substance use?** Yes  No

Details: Cocaine  MDMA  Cannabis  Cigarettes  Alcohol  Other: \_\_\_\_\_

**Homelessness?** Yes  No

Details: \_\_\_\_\_

**School avoidance?** Yes  No

Details: \_\_\_\_\_

**Extreme social withdrawal?** Yes  No

Details: \_\_\_\_\_

**Other:** \_\_\_\_\_

**5. REFERRER DETAILS**

Name of Referrer: \_\_\_\_\_ Date: \_\_\_\_\_

Service/Organisation: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Service Address: \_\_\_\_\_

*Do you wish to be part of our mailing list?* Yes  No