Referral Form

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|  *Please ensure all sections are completed and legible* ***post:*** *129 High Street, Shepparton 3630 or* ***fax:*** *03 58218678*headspaceShepparton is a voluntary service for young people between the ages of 12 and 25. headspace Shepparton can only engage with young people if they have consented to the referral.Has the young person given consent to the referral? Yes [ ]  No [ ] Is the young person aged between 12 and 25? Yes [ ]  No [ ] headspaceShepparton is not a crisis service. We are unable to support severe mental health issues or crisis referrals. Please call Goulburn Valley Area Mental Health Services Triage on 1300 369 005 if you have concerns. In an emergency call 000. |
| **Young Person Details** |
| First name: Surname: Gender: Male [ ]  Female [ ]  Other [ ]  Date of Birth: Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postcode: Phone (home): Phone (mobile): Email: Which contact/s would the young person prefer us to use? Home [ ]  Mobile [ ]  Email [ ] Language spoken at home: Preferred language: Interpreter needed: Yes [ ]  No [ ]  Indigenous Identity: Aboriginal [ ]  Torres Strait Islander [ ]  Both [ ]  Neither [ ] **Parent/Carer/Other Contact:**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to young person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Referrer Details** |
| Name of Referrer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to young person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Organisation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Does the young person see any other services at the moment? If yes, please tick appropriate box/boxes:Drug and Alcohol [ ]  School Counsellor [ ]  Other Counsellor [ ]  Youth Justice [ ] Community Services [ ]  Adult Mental Health [ ]  CYMHS (Child and Youth Mental Health Services) [ ] Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Does the young person have a regular GP?If yes, Name of GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Will your service continue working with the young person? Yes [ ]  No [ ]  |

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| **Reasons for Referral** |
| Mental health [ ]  Sexual Health [ ]  Drug and Alcohol [ ]  Diversity [ ]  Other [ ]  |
| Main Issues: |
| Pre-existing diagnosis/relevant past history: |
| What are your expectations of headspace Shepparton? |
| Other comments in regard to referral: |
| **Referral Contact** |
| Are the parents/carers aware of the referral? Yes [ ]  No [ ]  n/a [ ]  Who should we contact first in regard to this referral? [ ]  Referrer [ ]  Parent/carer/other  [ ]  Young personIf we are unable to contact the young person, can we contact the parent/carer/other contact? Yes [ ]  No [ ]  n/a [ ]  |

*Please inform young person/other referral contact that they will be contacted by phone on a private number*

Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Note: Referrals will be responded to within 3 working days. If you have not received confirmation of receipt of this referral, please call us on 03 5823 8800.

headspace Shepparton

129 High St, Shepparton 3630

T: 03 5823 8800 F: 03 5821 8678 E: headspace@gvhealth.org.au

[www.headspace.org.au/shepparton](http://www.headspace.org.au/shepparton)