Referral Form All enquiries welcome

The organisation that manages headspace Southport and headspace Upper Coomera is Lives Lived Well.

headspace Southport headspace Upper Coomera

**Email:** [reception@headspacesouthport.org.au](mailto:reception@headspacesouthport.org.au) **Email**: [reception@headspaceuc.org.au](mailto:reception@headspaceuc.org.au)

**Phone:** 07 5509 5900 **Fax:** 07 5527 1251 **Phone:** 07 5600 1999 **Fax:** 07 3568 8300

**PRIMARY REASON (S) FOR REFERRAL**

Mental Health Alcohol/Drug Use Physical Vocational Group Other Specify\_\_\_\_\_\_\_\_\_\_\_\_\_

Please see <https://headspace.org.au/headspace-centres/southport/> for **headspace Southport Early Psychosis Program** Referral Form

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: |  | Last Name: |  | | |
| Date of Birth: |  | Gender: |  | Pronouns: |  |
| Primary  Mobile  Contact & Name: |  | Secondary Phone Contact & Name: |  | | |
| Email: |  | | | | |
| Address: |  | | | | |
| Parent/ Guardian Name and Contact Number: (if consent given by young person) | | | | | |

**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.

Yes No

I give permission for headspace Southport and/or headspace Upper Coomera to use my contact details above for future contact with me.

Yes No

I give permission for the **staff** of headspace Southport and/or headspace Upper Coomera 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 Southport and/or headspace Upper Coomera.

|  |  |  |  |
| --- | --- | --- | --- |
| Signed |  | | |
| Print Name: |  | Date: |  |

If under 18 years of age, authorisation ideally would be provided by a parent/ guardian.

If under 16 years of age consent is required by a parent/ guardian

|  |  |  |  |
| --- | --- | --- | --- |
| Signed |  | | |
| Parent/Guardian Name: |  | | |
| Relationship: |  | Date: |  |

**REFERRER (INDIVIDUAL COMPLETING THIS DOCUMENT)**

|  |  |  |  |
| --- | --- | --- | --- |
| Contact Name |  | | |
| Position / Relationship: |  | | |
| Organisation (if applicable): |  | | |
| Phone: |  | Mobile: |  |
| Email: |  | Fax: |  |
| Signed: |  | | |

PRESENTING ISSUES

ADHD / ADD HARM OR THREATS TO OTHERS

ALCOHOL ABUSE HISTORY OF HOSPITALISATION

ANXIETY INTELLECTUAL DISABILITY

ASPERGERS / AUTISM LOSS OF APPETITE

BODY IMAGE LOW SELF ESTEEM

BULLYING OTHERS PENDING LEGAL MATTERS

CRYING PAIN MANAGEMENT ISSUES

DEPRESSION PHYSICAL ABUSE

DIFFICULTY SLEEPING PHYSICAL DISABILITY

DOCS PTSD

DOMESTIC VIOLENCE REFUSING SCHOOL

DRUG USE RELATIONSHIP ISSUES

EATING PROBLEMS SEXUAL ABUSE

EMOTIONAL ABUSE SELF HARM

FAMILY PROBLEMS SOCIAL PROBLEMS AT SCHOOL

FINANCIAL DIFFICULTY STRESS

FUNCTIONAL DECLINE SUICIDAL

­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­ HALLUCINATIONS AND DELUSIONS TRAUMA HISTORY

OTHER (PLEASE DESCRIBE)

|  |
| --- |
| CAN YOU TELL US MORE? (ABOUT THE BOXES TICKED ABOVE) |
|  |

**RISK TO SELF OR OTHERS (INCLUDE SELF HARM, SUICIDE ATTEMPTS, VIOLENCE, THREATS OF VIOLENCE)**

Please note:headspace **is not a Crisis Service,** if the young person is experiencing high levels of distress which may result in harm to themselves or others, please refer them directly to their local Emergency Department.

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

**OTHER AGENCIES/HEALTH CARE PROVIDERS CURRENTLY INVOLVED WITHIN THE YOUNG PERSON’S CARE**

**(IE. GOVERNMENT, NON-GOVERNMENT, GP’S, PSYCHIATRISTS AND COMMUNITY SERVICES)**

|  |  |  |  |
| --- | --- | --- | --- |
| Contact Person: |  | | |
| Organisation: |  | Phone: |  |
| Email: |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Contact Person: |  | | |
| Organisation: |  | Phone: |  |
| Email: |  | | |

**ELIGIBILITY CRITERIA:**

* Referrals from QLD Health and other service providers require a copy of ALL relevant collateral information (including assessment, discharge summaries & recovery documents) prior to referral being processed.
* Referrals from Probation and Parole require information on convictions and pending legal matters including dates, along with AOD information prior to referral being processed.
* General Practitioners can fax or email a Mental Health Care Plan to headspace Southport or headspace Upper Coomera instead of completing this referral.
* Referral to a group program for young people who are not headspace clients, to be eligible the young person is required to be under the clinical governance of a psychiatrist, private practitioner, case manager, GP or other QLD Health team.

For **headspace Southport**

Please **fax** or **email** referral form to: **(07) 5527 1251** or [**reception@headspacesouthport.org.au**](mailto:reception@headspacesouthport.org.au)

For more information please call: **(07) 5509 5900**

For **headspace Upper Coomera**

Please **fax** or **email** referral form to: **(07) 3568 8300** or [**reception@headspaceuc.org.au**](mailto:reception@headspaceuc.org.au)

For more information please call: **(07) 5600 1999**