**Family/Friends Referral**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** |  | | | | | | | | | | | |  | | | | | | | | | | | |
| **General Information** | | | | | | | | | | | | | | | | | | | | | | | | |
| **First Name** | | |  | | | | | | | | | | **Last Name** | | | |  | | | | | | | |
| **Alias / Skin Name / Preferred Name (i.e. Kuminljai)** | | | | | | | | | | | | | |  | | | | | | | | | | |
| **DOB** | |  | | | | | | | | | **Gender** | | Female Male  Gender Diverse Indeterminate Other | | | | | | | | | | | |
| **Sexuality** | | Heterosexual (Straight) Lesbian Gay Bisexual Other Sexuality (i.e. Queer, Pansexual, etc.) Questioning Choose not to answer | | | | | | | | | | | | | | | | | | | | | | |
| **Please specify if ‘Other’:** | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Relationship Status** | | | | | Single/Never Married In a relationship/Married/De Facto Divorced Separated Widowed Choose not to answer | | | | | | | | | | | | | | | | | | | |
| **Indigenous?** | | | | No Aboriginal Torres Strait Islander Aboriginal and Torres Strait Islander Choose not to answer | | | | | | | | | | | | | | | | | | | | |
| **Ethnicity (other than Aboriginal and/or Torres Strait Islander)** | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Country of Birth** | | | |  | | | | | | | | | **Town of Birth** | | | | |  | | | | | | |
| **If not Australian, year of arrival?** | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Main Language Spoken at Home** | | | | | | |  | | | | | | | | | **Other Languages** | | | | |  | | | |
| **Contact Details** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Address** | |  | | | | | | | | | | | | | | | | | | | | | | |
| **Town** | |  | | | | | | | | | | | | **State** | |  | | | | | **Postcode** | |  | |
| **Mobile Number** | | | | |  | | | | | | | | | | | | | | | | | | | |
| **Email** | | | | |  | | | | | | | | | | | | | | | | | | | |
| **Emergency Contact Details** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | | | | |  | | | | | | | | | | | | **Relationship** | | | |  | | | |
| **Mobile Number** | | | | |  | | | | | | | | | | | | | | | | | | | |
| **Next of Kin Details (If not the same as Emergency Contact Details)** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | | | | |  | | | | | | | | | | | | **Relationship** | | | |  | | | |
| **Mobile Number** | | | | |  | | | | | | | | | | | | | | | | | | | |
| **Health Care Card Information** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medicare Number** | | | | |  | | | | | | | | | | **Reference Number** | | | |  | | | **Expiry** | |  |
| **(If applicable) Centrelink Health Care Card Number** | | | | | | | | | | | |  | | | | | | | | | | **Expiry** | |  |
| **Service Information** | | | | | | | | | | | | | | | | | | | | | | | | |
| **What support would you like to access? (Tick more than one if applicable)** | | | | | | | | | | Doctor Psychologist/Mental Health Counselling  Work/Vocational Support AOD | | | | | | | | | | | | | | |
| **Please tick which boxes below apply to you for relevant information relating to why you are accessing our youth service:** | | | | | | | | | | | | | | | | | | | | | | | | |
| Feeling Sad or Depressed  Feeling Anxious  Concerned Sleeping  Concerned Eating  Self Esteem/Body Image  Relationship Issues  Substance Abuse (Alcohol/Drugs)  Financial Situation | | | | | | | | | Sexual Health  Sexuality Confusion/Questioning  Gender Confusion/Questioning  Living Situation  Work and Study  Disruptive Thoughts | | | | | | | | | | | Doctor Check Up  Anger and Aggression  Bullying  Stress  Loneliness  Nightmares | | | | |
| **Other:** | | | | | | | | | | | | | | | |
| **How long has/have this/these been an issue for you?** | | | | | | | | | Days (1-6) Weeks (1-3) Months (1-11) Years (1+) Unsure | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Referrer Information** | | | | | |
| **Referred by** | Family Member Friend Partner Carer | | | | |
| **Referrer Name:** |  | | | | |
| **Relationship:** |  | | **Phone** |  | |
| **Mobile** |  | | **Fax** |  | |
| **Email** |  | | | | |
| **Has the young person previously accessed a headspace centre before?** | | | | | Yes No Unsure |
| **Is the young person aware of this referral?** | | | | | Yes No Unsure |
| **If under 16, are the parents/carers aware of this referral (and willing to respect and comply with headspace policies)?** | | | | | Yes No Unsure |
| **Is the young person under the care of Territory Families or in alternative care arrangements (i.e. living away from home in foster care)?** | | | | | Yes No Unsure |
| **Does the young person currently access any other services (e.g. DASA, Anglicare)?** | | | | | Yes No Unsure |
| **Please Specify if ‘Yes’:** | |  | | | |
| **Does the young person have any previous (or current) Mental Health Treatment Plans (MHTP)?** | | | | | Yes No Unsure |
| **Please Specify Where/Who From if ‘Yes’:** |  | | | | |
| **Please provide any relevant information/details of why the young person requires general practitioner, counselling or vocational support below from your understandings:** | | | | | |
|  | | | | | |

**Please return this completed form to our headspace Reception in person or by fax or email.**