Please note that **headspace Greensborough and Plenty Valley is not a crisis service**. Crisis care can be accessed via;   
Under 18 Triage, 9am-5pm, Monday to Friday (Darebin, Whittlesea, Banyule, Nillumbik) 1300 859 789   
North East MH Triage Service 24 hours (Banyule, Nillumbik): 1300 859 789  
Northern MH Triage Service 24 Hours (Darebin, Whittlesea) 1300 874 243  
Eastern MH Triage Service 24 hours (Manningham): 1300 721 927

headspace Greensborough offers early intervention support for young people aged 12-25 years.

Date:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Young Person’s Details**  Young person is aware about and agrees to referral:  Yes | | | | |
| Title: | Name: | | | |
| Gender identity: | | Pronouns: | | DOB: |
| Address: | | | | |
| Phone: | | | Email: | |
| Preferred mode of contact:  SMS  Phone call  Email  Letter | | | | |

|  |  |
| --- | --- |
| Young Person’s Language and Culture | |
| Tick any that apply: | Aboriginal  Torres Strait Islander  Culturally and Linguistically Diverse |
| Does the young person require an interpreter?  No  Yes, please state what language (including Auslan): | |

|  |  |  |
| --- | --- | --- |
| **Emergency Contact** | | |
| Name: | Phone: |  |
| Relationship to young person: |  |  |
| If no emergency contact provided, please provide rationale |  |  |

|  |  |
| --- | --- |
| **Referrer Details** | |
| Name: | Role: |
| Phone: | Agency: |
| Fax: | Email: |

|  |
| --- |
| Referral Information |
| Does the young person have a Mental Health Plan?  No  Yes |
| Other organisations/supports in place (i.e. GP, school wellbeing, family services – please include role and contact information) |

|  |
| --- |
| **Presenting concerns** |
| *Eg*. *Current issues, duration of concerns, level of impact etc.* |
| **Reason for referral** |
| Brief interventions with counsellors (approx. 6 sessions, goal focused). **\*This is for people going through a tough time but not for those with very complicated mental health issues Please note that this support is unsuitable for people needing specialist or long-term supports.**  headstart (Single Session Therapy)  Employment support  Alcohol or other drug support  Physical/ sexual health consultation  Groups  Other, please comment below; |

|  |
| --- |
| **Relevant background and additional information** |
|  |

|  |
| --- |
| **Risk and safety concerns** |
| Suicidal ideation  Historic or current suicidal behaviours  Non suicidal self-injury or self-harming behaviours  Alcohol or other drug use  Risk taking behaviours  Historic or current family and/or domestic violence  Safety plan completed (please attach with referral)  Comments (if yes, please provide more information); |

|  |
| --- |
| **Consent** |
| I, [carer’s name if young person under 16, young person’s name if 16 or over], give consent for this referral to be made and give permission for \_\_\_\_\_ [referrer name] to exchange information with headspaceGreensborough for the purpose of this referral.  Young person/carer signature: Date:  OR Tick if verbal consent was obtained |

Please send through any relevant documentation with your referral (i.e. MHCP, assessments or discharge plan) via email to: [headspacegreensborough@mindaustralia.org.au](mailto:headspacegreensborough@mindaustralia.org.au?subject=Referral) or fax: 03 9435 8621