Referral Form

Date of referral:		**Is Young Person aware of referral?** Yes☐ No☐	
Referral type:	☐ Phone ☐ Fax ☐ Email ☐ Walk in	**Referral source:**	☐ Self ☐ Friend/Family Member ☐ School ☐ Doctor: _____ ☐ Service Provider: _____

Young Person Details

Name:		**DOB:**	
Address:		**Phone:**	
If we leave a message can we say we are from headspace? Yes☐ No☐			
Pronouns:	She/Hers ☐ Him/His ☐ They/Theirs ☐		
Gender:			
Medicare No:		**Reference No:**	
Expiry Date:			

Cultural Identity

Aboriginal: ☐ **Aboriginal & TSI:** ☐ **Torres Strait Islander:** ☐ **Non-Indigenous:** ☐ **Other:**
Country of Birth:

Emergency Contact Details

Name:	
Address:	
Phone:	
Relationship to Young Person:	
Can we contact this person about your appointments? Yes☐ No☐	

Reason for Referral

Mental Health ☐	**Physical Health** ☐	**Sexual Health** ☐	**Alcohol and Drugs** ☐
Situational ☐	**Vocational/Education** ☐	**Social Support** ☐	**Family Support** ☐
Eating ☐	**Home/Environment** ☐	**Friendships** ☐	**Relationships/Sexuality** ☐

Can you tell us a little more?

Details of Referrer

Name:		**Email:**	
Agency:		**Phone:**	

PLEASE FORWARD ANY AVAILABLE DOCUMENTATION:

Referral Letter	☐	**Notes**	☐
Discharge summary	☐	**Assessment**	☐
Mental health plan	☐		

Is the YP currently receiving support from another service? Yes☐ No☐
If yes, what service?

Client Consent

A part of the referral process to headspace Kalgoorlie is for us to learn about you and the other services involved in your life.

All information we find out about you, including from the HAPI (iPad) survey, will be treated confidentially, which means we will not share your information with anyone else unless you give us permission, or you are at serious risk.

I am involved in the following services and I consent (give my permission) to headspace Kalgoorlie to obtain the relevant information from the following people:

• I am aware that this referral is being made. I understand I can withdraw from headspace Kalgoorlie at any time.	☐ **Yes** ☐ **No**
• I understand that any information collected by headspace is stored confidentially. I give my permission for headspace Kalgoorlie to obtain relevant information from the people listed above and from the HAPI (iPad) survey conducted at the beginning of every appointment.	☐ **Yes** ☐ **No**

Do you give headspace consent to talk to any of the following?

☐ **CAMHS** (Child and Adolescent Mental Health Service)
☐ **CMHS** (Community Mental Health Service)

☐ **GP**: Name: _____ Practice: _____

☐ **High School Psychologist/Chaplin/Counsellor:**
☐ KBC ☐ EGC ☐GBC ☐JPC Name of contact Person: _____

☐ **Primary School Psychologist/Chaplin/Counsellor:**
School: _____ Name of contact person: _____

☐ **Government Service:** _____
☐ **Department of Child Protection and Family Support:** _____
☐ **Youth Justice:** _____
☐ **Adult Community Corrections:** _____
☐ **WA Police:** _____
☐ **Anyone else you can think of?** _____

Young Person's Name:	
Young Person's Signature:	**Date:**
If the young person is under 16 years of age, authorisation should where possible be provided by a parent/guardian/carer.	
Guardian Name:	
Guardian Signature:	**Date:**

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