MUNITY REFERRAL FORM

Referrer to complete form, fax (07 4661 1099) or email (headspace.warwick@rhealth.com.au) to headspace Warwick and follow-up with phone call to ensure receipt of referral.

**Referral criteria** – 12-25 years old; not acute; early intervention. **If a young person is at immediate risk of harm, please call 000.**

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| **Date of Referral:**  |
| **Client Details:** |
| Name: | DOB:  | Gender: |
| Address:Parent/Carer (if required):  | Phone: Phone: |
| **Referrer’s Details:** |
| Name: | Position: | Phone:Fax: |
| Organisation: | Address: |
| **Reason/s for Referral:**  |
| Is the client linked with other services? | If “Yes”, please provide details: |
| 🞎 Yes 🞎 No |  |
| **CLIENT CONSENT** |
| This referral must be discussed with the client. **headspace** Warwick is unable to contact them without their consent. |
| Do you have the client’s consent for this referral? *(Where possible, please have the client sign below)* | * Yes
 | * No
 |
| If under 16 years of age, are the parents/carers aware of this referral? | * Yes
 | * No
 |
| Client signature: |  |  | Date:  |  |
| Referrer’s signature: |  |  | Date: |  |

**Please note**: **headspace** Warwick will contact the referrer to advise of the young person’s **attendance** or **non-attendance** at **headspace** Warwick. Specific details of the outcome of the contact will not be discussed unless the young person has provided their consent to release of information.MENTAL HEALTH NURSE ICENTIVE PROGRAM