

# Referral Form

Referral Date:

## Important information for your referral, Please Read

- headspace is a service for young people between the ages of 12 to 25.
- We can only engage with young people who have provided consent to the referral. If the young person is at high or acute risk of suicide, please contact the Mental Health Line on 1800 011 511 or emergency services on 000 if urgent.
- Please note that receipt of the referral form does not indicate acceptance to the headspace services. Suitability of the referral will be determined following assessment with the young person. Please contact headspace Newcastle to confirm receipt and discuss the outcome of your referral.
- To complete the referral, you must attach relevant assessment notes, discharge summaries and/or additional information.

## Consent to Referral

Has the young person given consent for the referral?	Yes	No	
Has the young person's parents(if under 16) consented to the referral?	Yes	No	N/A(16yrs+)
Are parents aware that they will need to attend appointments (particularly for those aged 15years or under)	Yes	No	N/A(16yrs+)
Does the YP have a Mental Health Care Plan? If no, please encourage young person to obtain this as this will assist speed up the allocation process	Yes	No	

## Young Person's Details:

Name:	Pronouns:	Gender:
Date of Birth:	Age:	Contact Number:
Address:	Suburb:	Postcode:
Medicare Card:	Ref:	Exp:
	Email:	

**Does the young person identify as:**  
 Aboriginal Torres Strait Islander    Aboriginal & Torres Strait Islander  
 Culturally & Linguistically Diverse (CALD)    LGBTQIA+    None    Unknown

**Does the young person have any difficulties with literacy?:**  
 No    Yes, please explain:

**Does the young person have any difficulties with accessibility/mobility?:**  
 No    Yes, please explain:

**Referral Method:**  
 Referral (Family/Friend)    Self (Phone/Email/Walk-in)    GP    Other Service:

## Required Services: Please indicate which services would be beneficial

Mental health support  
Vocational support

Physical health support (GP)

Drug and alcohol support

## Next of Kin: This should be the young person's closest living relative.

Name: Relationship to YP:

Address: Contact Number:

Name/ relationship: Contact Number:

Name/ relationship: Contact Number:

## Referrer Details:

Name of Referrer: Organisation:

Relationship to YP: Contact Number:

Address:

Email:

## Presenting Issues

Anger	Anxiety	Bullying	Depression	Relationships
Self-Harm	Stress	Substance Use	Suicidal Ideation	Trauma
Other (E.g. Legal Issues)		Details:		

## Referral Information (please complete this section)

Please attach any extra relevant information and assessments e.g. risk information, legal information, current presenting issues, impact of problem on functioning, family history of mental health conditions

**Tertiary Mental Health Services:** Please attach Risk Assessment, A1, Discharge Summary

**\*\*Please note we may be unable to process/accept referral if this information is not received**

(Please attach additional documentation should you require more space)

Thanks for making a referral to headspace Newcastle. You can return the referral form by:

Fax (02) 4925 2864

Email [intakeheadspacenewcastle@hunterprimarycare.com.au](mailto:intakeheadspacenewcastle@hunterprimarycare.com.au)

**I'd like to be on headspace Newcastle's email list**

Joining the email list will allow us to inform you of upcoming programs, events and projects that may be of interest. Your email address will not be shared with any other organisations

**If you would like to discuss this referral please contact  
headspace Newcastle staff on (02) 4929 4201**

NB: the paper version of this document has been destroyed  
Adapted with thanks from headspace MtDruitt, Parramatta, and Penrith