|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Young Person’s Details: | | | | | | | | |
| **Full Name:** | | |  | | **Preferred Name:** | | | |
| **Date of Birth:** | | |  | | **Gender:** | Male Female Other | | |
| **Phone number:** | | |  | |  | | |  |
| Can we SMS to confirm appointments? | | | | |  | | YesNo | |
| **Address:** | | |  | | | | | |
| **Town/Suburb:** | | |  | | **Post Code:** |  | | |
| **Email address:** | | |  | | | | | |
| **Is the young person aware of the referral?** | | | | | | | YesNo | |
| **If the young person is under 16, is their parent/caregiver aware of the referral?** | | | | | | | YesNo | |
| Family Member/Emergency Contact: | | | | | | | | |
| **Full Name:** |  | | | | **Phone number:** | | | |
| **Relationship to young person:** | | | |  | | | | |
| Referrer Information: | | | | | | | | |
| **Name:** | |  | | | **Phone number:** |  | | |
| **Email:** | |  | | | | | | |
| **Relationship to young person:** | | | |  | | | | |
| **Position and Organisation:** | | | |  | | | | |
| **Does the young person currently receive support from any other services?** If so, please specify who, from which service(s), and their contact details. | | | | | | | Yes No | |

Please note: **headspace** Mount Gambier isn’t a crisis service, or an acute mental health service.  
For emergency mental health support, please contact the emergencies services, on 000.  
  
**GPs to complete a Mental Health Treatment Plan. Completed referrals to be emailed to** [**headspacemountgambier@unitingcommunities.org**](mailto:headspacemountgambier@unitingcommunities.org)  
It is important that the young person is aware of this referral and agrees to attend appointments at **headspace** Mount Gambier.

Enter text

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Appointments: | | | | | | | | | | |
| **Preferred appointment method:** | | | | | | In person Phone Digital | | | | |
| **Who should be contacted to book appointments?**  Young person  Referrer Family member | | | | | | | | | | |
| **Does the young person have a Mental Health Treatment Plan:** | | | | | | | | | | Yes No |
| **Have any relevant assessments been completed?** *If so, please attach* | | | | | | | | | | Yes No |
| **Are you concerned with this person’s risk towards themselves or others?** *If you have answered ‘yes’ – please identify how, and provide as much detail as you can.* | | | | | | | | | | Yes No |
|  | | | | | | | | | | |
| What is the reason for referral? | | | | | | | | | | |
| **Anxiety** | | **Conflict in Relationships** | | | **Stress related** | | | | **Social isolation** | |
| **Depression** | | **Alcohol/Substance use** | | | **Medical issues** | | | | **Other** | |
| Please provide a brief explanation of the presenting issues, and what type of support are you requesting for the young person?  Consent: | | | | | | | | | | |
| *If young person is under 16 years of age, a parent/guardian must provide consent.* | | | | | | | | | | |
| **Consent type** | Verbal Written | | | **Person consenting** | | | | Young Person Advocate | | |
|  |  | | | **Advocate’s name:** | | | |  | | |
| I \_\_\_\_\_\_\_\_\_(young person) , being 16 years or older, agree to be referred to headspace Mount Gambier and give my permission for \_\_\_\_\_\_\_\_\_\_\_\_(referrer) to exchange information with headspace Mount Gambier for the purpose of this referral. I \_\_\_\_\_\_\_\_\_\_\_\_\_\_(parent/guardian) agree for \_\_\_\_\_\_\_\_\_\_(young person) to be referred to headspaceMount Gambier and for information to be shared as above. | | | | | | | | | | |
| **Young person/advocate signature:** | | |  | | | | **Date:** | | | |
| **Referrer signature:** | | |  | | | | **Date:** | | | |