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| Young Person’s Details: |
| **Full Name:**  |  | **Preferred Name:**  |
| **Date of Birth:**  |  | **Gender:** | [ ] Male [ ] Female [ ] Other |
| **Phone number:**  |  |  |  |
| Can we SMS to confirm appointments? |  | [ ] Yes[ ] No |
| **Address:** |  |
| **Town/Suburb:** |  | **Post Code:** |  |
| **Email address:** |  |
| **Is the young person aware of the referral?** | [ ] Yes[ ] No |
| **If the young person is under 16, is their parent/caregiver aware of the referral?** | [ ] Yes[ ] No |
| 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**
It is important that the young person is aware of this referral and agrees to attend appointments at **headspace** Mount Gambier.

Enter text

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| 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**  | [x]  **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:**  |