Referral Form

And Referral Guidelines

headspace Armadale is a free, youth-friendly and confidential service available to young people aged 12 – 25 years, in the south east metropolitan region of Perth. **headspace** Armadale brings together a range of co-located community-based and government agencies, to provide a holistic service as a "one-stop-shop" for young people. We offer information, intake, assessment and referral.

The services available at **headspace** Armadale include:

- Youth Friendly General Practitioner/s
- Youth Support Workers
- Sexual health clinic
- Drug and alcohol outreach worker
- MBS & ATAPS Psychological services
- Vocational support worker

How to refer

Professional Referral

- Referrals accepted from GP's, Allied Health Professionals, community-based agencies and educational institutions
- Where available, GP's should include a copy of the client's Mental Health Treatment Plan

Self-referral

- By phone/ email: please call 08 9458 0505 or email info@headspacearmadale.com.au (please note these are only attended/checked during business hours)
- Drop in: Young people can drop in to **headspace** Armadale between 9am and 5pm, Monday – Friday. Staff will endeavour to see the young person the same day or the next available appointment will be offered

Family Referral

- Families, carers of friends can refer a young person to **headspace** Armadale. The young person needs to be aware of and consent to the referral and be willing to meet with a member of the **headspace** Armadale team

Client Details

Date of Referral	**DOB** / / **Age**	
Name	**Gender** ☐ Male ☐ Female ☐ Transgender	
Address		
Email	**Mobile**	**Home Phone**
Medicare No. ***(nothing billed without prior consent):***	**Reference No.**	**Expiry Date:**
Are there any safety concerns when contacting the patient by phone/mail?		

Consent to contact young person via: (e.g. confirm appointments etc.)

Mobile: ☐ Yes ☐ No **Text:** ☐ Yes ☐ No **Voicemail:** ☐ Yes ☐ No

Email: ☐ Yes ☐ No **Mail:** ☐ Yes ☐ No **At home:** ☐ Yes ☐ No

Preferred method of contact ***(this can change and other arrangements can be made):***

Ability to speak English? ☐ Very well ☐ Well ☐ Not well ☐ Not at all **Preferred Language**…

What is the client's country of origin? **What is the client's visa status?**

Is the person Aboriginal or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, TSI ☐ Unknown

Who does the young person live with?

Education/employment status?

Emergency Contact Information (MUST be completed if client is under 16 unless mature minor process followed)

Emergency contact name .... **Mobile number** ....

Relationship to client .... **Home number** ....

Is the young person's parent/guardian aware that this referral has been made? ☐ Yes ☐ No

ABN 71 131 368 735
headspace National Youth Mental Health Foundation Ltd is funded by the Australian Government Department of Health under the Youth Mental Health Initiative Program

Reason for Referral

Presenting Issues *(please include here any information which may be useful as background information to assist with the referral e.g. mental health, drug and alcohol, vocational/educational, physical health, including past/current risk assessments)*

☐ Mental health ☐ Physical health ☐ Sexual health ☐ Alcohol/drugs
☐ Situational ☐ Vocational/education ☐ Social support ☐ Family support
☐ Eating ☐ Home/environment ☐ Friendships ☐ Relationships/sexuality

Mental health diagnosis (if relevant) .... *(Please attach copy of current Mental Health Treatment Plan if available)*

Recent Stressors *Are there any legal proceedings pending? (please note headspace is unable to provide opinion re: legal matters or supporting documents)*

Client History *(Relevant biological, psychological, physical and social history, including family history)*

Relevant medications: ....

Risk to self or others *(include self-harm/suicide attempts, violence, threats of violence)*

PLEASE NOTE: headspace does not provide crisis or acute care, if in crisis please refer to the closest Emergency Department or call the Mental Health Emergency Response Line (MHERL) on 1300 555 788

Other Care Providers Involved *(is the young person linked in with any other services? For example. CAMHS, YouthLink etc.)*

Referrer Details

Name .... **Profession** ....

Address ....

Organisation .... **Contact Number** ....

Client's GP (if not the referrer):

Name .... **Practice** ....

Address ....

Consent Details

Please indicate who is consenting to collection, use and disclosure of personal health information:

☐ Adult client ☐ Adolescent client (aged 16 or over) ☐ Parent/guardian ☐ Mature minor

All information will be treated confidentially and will not be used for any other purposes that what is stated in the full consent form (signed during the first appointment). I am aware that this referral is being made. I understand I can withdraw from this service at any time. The client has been made aware of this referral.

Client name **Client signature** **Date**

Parent/guardian name **Parent/guardian signature** **Date**

FAX THIS REFERRAL TO HEADSPACE ARMADALE ON 9458 0555 or email to info@headspacearmadale.com.au

A worker will contact the young person within 1 – 3 working days.

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