PROFESSIONAL REFERRAL FORM

STOP: If you are a young person, family, friend or carer please use the 'Self referral' form

PLEASE RETURN COMPLETED FORM TO:
Address: 1/33 Steele Street, Devonport **Phone:** (03) 6424 2144 **Fax:** (03) 6424 6102
Email: devonport@csys.com.au **Website:** www.cornerstoneyouthservices.com.au

Please Note: headspace Devonport is not an acute mental health service or crisis service. If you have concerns for a person's immediate safety please contact the Mental Health Helpline on 1800 332 388. For urgent medical assistance please call: 000.

YOUNG PERSON DETAILS:

Contact details: First Name: _____Last Name: _____

Gender: _____ Date of Birth:_____

Address:_____ Post Code: _____

Home Phone:_____ Mobile Phone: _____

Email:_____

Which contact/s would you prefer us to use? (You can Tick more than one)

☐ Mobile ☐ Home ☐ Phone ☐ Email ☐ Voicemail ☐ Letter

Who should headspace Devonport contact to make an appointment: Young Person / Referrer / Family member

Is the young person Aboriginal or Torres Strait Islander? YES/NO/ BOTH (Please Circle)

Preferred Language_____

Do they require an Interpreter YES / NO (please circle)

Does the young person have a current Mental Health Care Plan YES/NO

REFERRER INFORMATION:

Name: _____ Organisation: _____

Role:_____

Will you or another organisation have continued contact with the young person: YES / NO

Referrer Phone Number: _____Email_____

Is the young person aware of this referral? YES / NO (please circle)
We are unable to make contact with them if the answer is NO.

OTHER SUPPORTS / ORGANISATIONS
Is there a Family Member / worker you would like us to speak to? YES / NO (please circle)

Name_____ Phone/Mob_____

Relationship to young person ?_____

If under 16 are the young person's parents / carers aware of this referral? YES / NO (please circle)

Is the young person working with any other organisations if yes please list

_____

_____

Does the Young person have an NDIS Plan? YES / NO

Emergency Contact / Next of Kin MUST BE OVER 18:

First Name_____ Last Name_____

Relationship to YP _____ Phone_____

Medicare / Centrelink: (if known)
Medicare Card Number _ _ _ _ _ _ _ _ _ / _ Ref _ _ Line Number _ Expiry Date _ _ /_ _ /_ _

Does the young person have a regular Doctor? Name_____
Medical Practice_____

Does the young person have a Health Care Card or Pension Card? YES / NO

Centrelink Reference Number _ _ _ _ _ _ _ _ _ / _ Expiry Date _ _ / _ _ / _ _

REASON FOR REFERRAL : Please list main reasons for referral; please attach any relevant assessments/information if you require more space.

Health:
Are there any general health issues limiting the young person's day to day or social activities?
YES / NO (please circle)

Drug and Alcohol:
Are drugs and/or alcohol having a negative impact on areas of the young person's health or lifestyle?
YES/NO (please circle)

Education and Training:
Does the young person require support with education, training and/or employment
YES / NO (please circle)

An access worker from headspace will be in contact with the young person or family within 48 working hours. Please make contact and request to speak with the headspace access worker or email devonport@csys.com.au if you have any questions or further information.

Office use only:
Admin Signature
Date__ /__ /__
Time _____