



REFERRAL FORM

ELIGIBILITY CRITERIA:

- General Practitioners are able to fax/email a Mental Health Care Plan to **headspace** Meadowbrook instead of completing this referral form.
- **Referral from Service Providers will require a copy of ALL relevant collateral information** (including any assessments, discharge summaries & recovery documents) **prior to the referral being triaged.**
- **headspace** Meadowbrook works under **Medicare Billing Model (MBS)**, this means clients are only **eligible up to 10 Sessions** with Private Practitioners (Psychologists, Social Workers, Occupational Therapists). We also have ATAPS Providers onsite where young people are able to access up to 12 sessions if assessed to meet the criteria by a GP.
- Referrals from **Probation and Parole** require social history, information on convictions and pending legal matters including dates, **prior to referral being triaged.**

1. REFERRER (INDIVIDUAL COMPLETING THIS DOCUMENT)

Contact Name: _____

Position / Relationship: _____

Organisation (if applicable): _____

Postal Address: _____

_____ Post Code _____

Phone: _____ Mobile: _____

Fax: _____ Email: _____

Signed: _____

2. YOUNG PERSON BEING REFERRED (THESE DETAILS WILL BE USED TO CONTACT THE YOUNG PERSON /PARENT, GUARDIAN)

First Name: _____ Surname: _____

Date of Birth: _____ Age: _____ Gender: M F Other

Address: _____

Suburb: _____ Postcode: _____ State: _____

Home Ph: _____ Mobile: _____

If consent provided by young person please provide details of their parent/ guardian: _____

NOTE TO REFERRER

Please provide as much information as possible as it ensures the best quality of care, outcome and if required referral is afforded to the young person being referred.

If the young person is experiencing high levels of distress which may result in harm to themselves or others, please refer them directly to your local Emergency Department or a GP for immediate assistance as headspace is not a Crisis Service or equipped to manage these types of emergencies.

3. REASON FOR REFERRAL:

- Physical Health Mental health Alcohol/Drug Vocational Assessment
- Other - please specify _____

4. INFORMATION ABOUT THE YOUNG PERSON

(If Applicable) Risk to self or others (Include self-harm/ suicide attempts, violence, threats of violence)

Date	Type of Behavior	Reason for Behavior	Outcome/ Treatment Provided

(If Applicable) Other Agencies / health care providers currently involved within the individuals care: (e.g.: Government, non Government, GP's, Psychiatrists, and Community Services)

Name of Organisation	Contact Person	Address	Phone

5. PRESENTING ISSUES

- | | | | |
|--------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> PAIN MANAGEMENT ISSUES | <input type="checkbox"/> ADHD / ADD | <input type="checkbox"/> REFUSING SCHOOL |
| <input type="checkbox"/> FAMILY PROBLEMS | <input type="checkbox"/> FINANCIAL DIFFICULTY | <input type="checkbox"/> DIFFICULTY SLEEPING | <input type="checkbox"/> DEPRESSION |
| <input type="checkbox"/> PHYSICAL ABUSE | <input type="checkbox"/> LOSS OF APPETITE | <input type="checkbox"/> EATING PROBLEMS | <input type="checkbox"/> SELF HARM |
| <input type="checkbox"/> RELATIONSHIP ISSUES | <input type="checkbox"/> PHYSICAL DISABILITY | <input type="checkbox"/> DRUG ABUSE | <input type="checkbox"/> HISTORY OF HOSPITALISATION |
| <input type="checkbox"/> HARM OR THREATS TO OTHERS | <input type="checkbox"/> SEXUAL ABUSE | <input type="checkbox"/> INTELLECTUALLY IMPAIRED | <input type="checkbox"/> STRESS |
| <input type="checkbox"/> DOMESTIC VIOLENCE | <input type="checkbox"/> PTSD / TRAUMA HISTORY | <input type="checkbox"/> BODY IMAGE | <input type="checkbox"/> SUICIDAL |
| <input type="checkbox"/> EMOTIONAL ABUSE | <input type="checkbox"/> SOCIAL PROBLEMS AT SCHOOL | <input type="checkbox"/> BULLYING OTHERS | <input type="checkbox"/> PENDING LEGAL MATTERS |
| <input type="checkbox"/> PRESENTATION TO ED OR HOSPITAL | <input type="checkbox"/> HALLUCINATIONS AND DELUSIONS | <input type="checkbox"/> CRYING | <input type="checkbox"/> ASPERGERS / AUTISM |
| <input type="checkbox"/> PAST OR PRESENT CONTACT WITH CHILD SAFETY | | <input type="checkbox"/> OTHER _____ | |

Do you have any final comments or relevant information?

6. CONSENT OF YOUNG PERSON BEING REFERRED

I am aware that this referral is being made. I understand that I can withdraw from this referral or from the referred service at any time.

Please NOTE: Referrals will not be processed without signed consent.

I give permission for **headspace** Meadowbrook to use my contact details above for future contact Yes No with me.

I give permission for the **staff** of **headspace** Meadowbrook to obtain relevant information from Yes No government and non-government agencies, from doctors and other health professionals specifically relevant to my care whilst being a client of **headspace** Meadowbrook.

I give permission for **headspace** Meadowbrook to contact the referrer and advise once an Yes No appointment has been arranged.

Signed: _____ Print Name: _____ Date: _____

If under 18 years of age authorisation ideally should be provided by a parent/ guardian.

Parent/ Guardian Signed: _____ Print Name: _____ Relationship: _____

7. THANK YOU FOR YOUR REFERRAL

Please return this form to headspace Meadowbrook

PO Box 220 Waterford, QLD 4131
260 Loganlea Road, Meadowbrook
Ph 07 3804 4200
Fax 07 3804 4299

Email headspace.meadowbrook@aftercare.com.au

8. WHAT NEXT?

- On receipt of a referral form **headspace** Meadowbrook will contact the service provider to advise of outcome and then if applicable contact the young person to arrange an appointment.
- All initial appointments will be with a **headspace** Meadowbrook intake/assessment officer, this process takes between 1 – 2 hours.