headspace Inala Referral Form

Please return to:
Email: headspaceinala@accoras.org.au
Phone: (07) 3727 5000
Fax: (07) 3279 8444
Address: PCYC Inala, 37 Swallow Street, Inala, Queensland 4077

This form collects information relating to the child/young person and their parent/carer and confirms the details provided by the referrer. By completing this form, you agree to general collection, use and storage by Accoras.

Please read these important information before submitting your referral

- headspace Inala is a voluntary service and offers free mental health support and intervention services for **young people aged 12-25.**
- Young people can only be engaged by us who have provided **their consent to the referral.**
- In the event of high or acute risk of suicide, **please contact emergency services at 000**.
- Please note, the acknowledgement email is to **indicate that we have received your referral form, but it does not indicate the acceptance to headspace Inala**. An assessment of suitability for the referral will determine the outcome of the referral. Nonetheless, we will get back to you that the referral is not suitable and provide contacts for more appropriate services.
- We endeavor to respond to referrals within 3 business days.
- Our Centre is fully wheelchair accessible.

Date of Referral:

Consent for Referral from young person: *(A separate consent form will be provided and explained during the intake appointment in relation to information sharing)* Has the young person consented to and provided permission to exchange information in relation to this referral?	☐ Yes ☐ No

Primary Reason(s) for Referral: This section must be completed.

☐ Short Term Mental Health Intervention
☐ Drug and/or Alcohol Support
☐ Vocational Support (Work and/or Study)
☐ Physical Health Support
☐ Other:

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Young Person's Details			
First/Birth Name		Last Name	
Preferred first name		Date of Birth	
Gender Identity		Assigned Sex at Birth	
Pronouns	he/him ☐ she/her ☐ hey/them ☐ Others:_____		
Street Address			
Suburb		Postcode	
Contact number			
Email address			
Country of birth		Ethnicity	
Interpreter required?	☐ No ☐ Yes If yes, language of interpreter:		
Does the young person identify as a member of one of the following groups?	☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Neither		

Parent or Carer Details (if applicable): Please note that if the young person is aged 16 and under, we will require a parent or legal guardian to be documented on this form and attend the first appointment. This is also a voluntary service and parent, or consent is mandatory for us to start working with the young person below the age of 16.			
Full name			
Relationship to young person			
Street Address			
Suburb		Postcode	
Contact number			
Email address			

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Do we have permission to speak with this person:	☐ Yes	☐ No
Who is the best contact for appointment bookings?	☐ Young Person	☐ Parent/Guardian
☐ Other		
Name:	Relationship to young person:	
	Contact Number:	

Presenting Issues

Current Presenting Issues (Please include duration, age of onset and any other relevant information)

Any impact on functioning (e.g: relationship/school/home/work/decline in function)?

Any known family history of mental health conditions?

Any previous/current engagement with other services (please list all organisations)?

☐ Consent to contact other services

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Risk Factors

- ☐ Suicide Attempt/s
- ☐ Suicidal Ideation
- ☐ Homelessness
- ☐ Non-Accidental Self-Injury
- ☐ Substance Use
- ☐ Depression
- ☐ Harm to Others
- ☐ Misadventure
- ☐ Withdrawal
- ☐ Eating Disorder
- ☐ Anxiety
- ☐ Other: _____

Please provide further details below:

Referral Date:
Referrer's Name:
Referrer's Initials:
Relationship to young person:
Referrer tile and organization (or n/a):
Referrer contact number/s:
Referrer email address:

By signing this document, the referrer agrees that the above information is a true and accurate record

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Emergency and Crisis Support

If the young person is in distress or at immediate risk of harm (or harming someone else), you must call 000,or present with them to the closest hospital emergency department. headspace Inala is not an emergency or crisis service and does not provide after-hours support.

- eheadspace 1800 650 890
- Lifeline 13 11 14
- Beyond Blue 1300 22 4636
- Kids Helpline 1800 55 1800
- Suicide Call Back Service 1300 659 890
- Mental Health Access Line 1300 64 22 55

Please email this form to headspace Inala at headspaceinala@accoras.org.au.

We will acknowledge your referral within two working days.

For any non-urgent questions, please email us, or call (07) 3727 5000.