Intake Form

Email to: **info@headspaceliverpool.org.au**

Fax referral to: **02 8107 6188**

- We strongly recommend anyone referring a Young Person to also **call and speak to an Intake Worker** on 02 8107 6100. Our opening hours are 8.30am to 5.00pm, Monday to Friday.
- Referrals are considered the week after we receive them. We'll be in touch after that to offer an appointment or to discuss who might be in a better position to support you / the Young Person.
- **We are not an emergency service**. If you / the Young Person needs immediate assistance, please call the mental health care line **(1800 011 511)** or go to the nearest hospital emergency department.

Date of referral:

Intake Officer (If applicable):

(Office Use Only) **Introduction**	
Introduced self, role and service	☐
Checked 3 identifiers – Name, DOB, Address	☐
Explained confidentiality and informed consent, including limits of confidentiality	☐

Referrer details (if applicable)	
Name:	**Relationship (Position and Organisation if appropriate):**
Best contact number:	**Email:**

Consents	
Who is the best person to contact about this referral?	☐ YP ☐ Parent / Guardian ☐ Referrer
Does the YP know and consent to this referral and to taking part in an assessment?	Yes ☐ No ☐ (intake cannot proceed – please discuss this first with YP)
Does the YP/referrer give permission for headspace to seek information from previous services they have engaged with?	Yes ☐ No ☐
If under 14 years, do the parent/carers consent to treatment?	Yes ☐ No ☐
Headspace collects some information by way of an online survey. Is the YP happy to complete this?	Yes ☐ No ☐

Contact Details		
Name:		
Age:		
Date of Birth:		
Gender:	☐ Female ☐ Male ☐ Transgender (F-M) ☐ Transgender (M-F) ☐ Non-binary ☐ Other	
Pronouns used:		
Address:		
Who do they live with?	☐ At home with family ☐ Living alone ☐ Refuge ☐ Staying with friends ☐ Homeless ☐ Supported accommodation	
Phone Number (YP or carer):		
Email (YP or carer):		
Name and phone of parent/guardian in case of emergencies:		

Family and Friends Involvement	
Headspace values the involvement of family wherever possible. **Does the young person have any family and friends they would like involved (name / relationship)?**	
Does the young person have any concerns about involving family?	

Work and Study	
Does the YP have a daytime activity?	☐ School ☐ Work ☐ University ☐ Volunteering
Details (where / what year / what are they studying etc)?	
If the YP is not working / studying, would they be interested in accessing support from headspace work and study?	

Cultural Background	
What cultural background does the YP identify as:	
Would an interpreter be helpful for the YP or family?	Yes ☐ No ☐ Details

Is YP from a refugee background?	Yes ☐ No ☐ Details
Is YP of Aboriginal or Torres Strait Islander background?	Yes ☐ No ☐

Referral Information
What's lead to referring to headspace? What are the current concerns?
Is the YP at risk of harming themselves or others? *Please note the importance of completing this section with detail. This allows us to determine the level and immediacy of risk, and ensures appropriate interventions are placed.* Suicidal ideation: Nil ☐ Historical ☐ Current ☐ ***risk assessment = scored…. (Level of risk) *** *refer to risk assessment on last page for score/level of risk, if there is any mention of suicidality.* Details (thoughts, plans/intentions/ability to keep safe? Attempts – number, means, most recent date?): Self-harm: Nil ☐ Historical ☐ Current ☐ Details (frequency, weapon, wound care, others aware, last episode?): Risk to others: Yes ☐ No ☐ Details:
Anything else happening that might be affecting the YP? (e.g. family issues, exam stress, issues with friends or relationships). Anything from the past that might be affecting the YP now?
Any previous mental health support / treatment, counselling, medication or diagnoses? What other supports are in place for the YP (organisations / services)?
What does the YP feel would be useful about coming to headspace? How motivated are they to come?

Any other information that may be relevant? (e.g. family history of mental health issues, court involvement, intellectual disability, physical disability)
Does the young person have any physical health concerns? Is body image / self esteem a concern? Is drugs and alcohol a concern for the YP?

GP	
Does the YP have a GP?	Yes ☐ No ☐
Is there a current Mental Health Care Plan?	Yes ☐ No ☐
GP Name:	**Medical Centre / Practice:**
If applicable: Medicare card no / reference / expiry: Centrelink Concession card CRN / expiry:	

(Office Use Only) **Clinical Comments**

Suicide Screen. Please complete if the young person has indicated ANY suicidal thoughts / ideation above.

In the past month, have you:					No	Yes
a.	Thought that you would be better off dead				0	1
b.	Want to harm yourself				0	2
c.	Think about suicide				0	6
d	Have a suicide plan				0	10
e.	Attempt suicide				0	10
f.	**Have you ever in your lifetime make a suicide attempt:**				0	4

Score	

0	no current risk
1 - 5	low risk
6 - 9	moderate risk
10+	high risk

- Please consult immediately with the Clinical Lead for any young person who scores in the high risk category.
- Please complete a safety plan for any young person who scores in the moderate risk category and provide while you wait options including the link for the beyond blue safety plan. Please highlight the moderate score on the intake form. Consult with Clinical Lead if appropriate.
- Please confirm with any young person in the low risk category whether they can stay safe until we contact them and provide while you wait options.

For all young people, please remind them to call us if their circumstances change or they feel they cannot stay safe. Please provide while you wait options and information regarding the wait list groups.

For more information, please refer to the Clinical Handbook and Clinical Governance framework but always remember that if you are concerned, communicate this with the Clinical Lead or Manager.