**Date**:

Is the Young Person aware of this referral? [ ]  Yes [ ]  No

if under 16 are the parents/carers aware? [ ]  Yes[ ]  No

is the young person 12 – 25? [ ]  Yes [ ] No

**Name**: preferred Name:

**Address**:

**Email:**

**Phone Number**: **DOB**: / /

**Gender**: [ ]  male [ ]  female [ ]  transgender [ ]  intersex [ ]  not stated

**Reason for referral?**  [ ]  Mental Health Counselling/Psychologist/social worker [ ]  Doctor

[ ] other:

**Referred by**  [ ] Self [ ] family/friend [ ] **Organisation** (specify)

**Contact person**:  **PH**:

**Email:**  **Fax**:

**Has the young person previously seen headspace**? [ ]  Yes [ ]  No
**does the young person have a mental health care plan?** [ ]  Yes [ ] No

**Does the Young Person see any other services at the moment?** [ ] Central Australia Mental Health Service

 [ ] Mental Health Association of Central Australia [ ] Drug &Alcohol [ ]  ASYASS

 [ ] Youth Service/S [ ] Other/s

**Relevant Information:**