**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:**