Referral to headspace

Date: _____

Is the young person to attend **headspace** at Bathurst ☐ OR Cowra ☐

Is the young person (YP) aware of this referral? Yes ☐ No ☐

If under 16 years, are the parents/carers aware? Yes ☐ No ☐

Has an appointment already been made by phone? Yes ☐ No ☐

If yes, indicate date and time of appointment: _____

Does the young person provide consent for feedback to be given to the referrer? Yes ☐ No ☐

Client name: _____ Client DOB: _____

Client Address: _____

Contact Phone Number: _____ (whose phone, ie young person, mum) _____

Referred by:

Contact Name: _____ Organisation: _____

Ph: _____ Mobile: _____

Email: _____ Fax: _____

Postal Address: _____

Reason for referral:

☐ Mental Health ☐ Physical Health ☐ Drug and Alcohol ☐ Vocational ☐ Other _____

Do you believe this young person is currently at risk of harm to themselves or other people? Yes ☐ No ☐

Relevant Information:

_____

_____

_____

_____

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Cnr Havannah and Piper Streets
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f +61 2 6338 1199
e headspace@hscw.org.au

Cowra
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