External Referral/Registration

headspace Alice Springs

Date	/ /

General Information			
First Name		**Last Name**	
Alias / Skin Name / Preferred Name (i.e. Kuminljai)			
DOB	/ /	**Gender**	Female ☐ Male ☐ Gender Diverse ☐ Indeterminate ☐ Other ☐
Sexuality	Heterosexual (Straight) ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Other Sexuality (i.e. Queer, Pansexual, etc.) ☐ Questioning ☐ Choose not to answer ☐		
Please specify if 'Other':			
Relationship Status	Single/Never Married ☐ In a relationship/Married/De Facto ☐ Divorced ☐ Separated ☐ Widowed ☐ Choose not to answer ☐		
Indigenous?	No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Choose not to answer ☐		
Ethnicity (other than Aboriginal and/or Torres Strait Islander)			
Country of Birth		**Town of Birth**	
If not Australian, year of arrival?			
Main Language Spoken at Home		**Other Languages**	

Contact Details					
Address					
Town		**State**		**Postcode**	
Mobile Number					
Email					

5/74 Todd St
Alice Springs NT 0870
headspace.org.au/alicesprings

T 08 8958 4544
F 08 7906 2244
E: headspace.reception@caac.org.au

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ABN 26 137 533 843

Emergency Contact Details			
Name		**Relationship**	
Mobile Number			

Next of Kin Details (If not the same as Emergency Contact Details)			
Name		**Relationship**	
Mobile Number			

Health Care Card Information					
Medicare Number		**Reference Number**		**Expiry**	/
(If applicable) Centrelink Health Care Card Number				**Expiry**	/

Service Information	
What support would you like to access? (Tick more than one if applicable)	Doctor ☐ Psychologist/Mental Health Counselling ☐ Vocational Support ☐

Please tick which boxes below apply to you for relevant information relating to why you are accessing our youth service:

☐ Feeling Sad or Depressed	☐ Sexual Health	☐ Doctor Check Up
☐ Feeling Anxious	☐ Sexuality Confusion	☐ Anger and Aggression
☐ Concerned Sleeping	☐ Gender Confusion	☐ Bullying
☐ Concerned Eating	☐ Living Situation	☐ Stress
☐ Self Esteem/Body Image	☐ Work and Study	☐ Loneliness
☐ Relationship Issues	☐ Disruptive Thoughts	☐ Nightmares
☐ Substance Abuse (Alcohol/Drugs)	**Other:**	
☐ Financial Situation		

How long has/have this/these been an issue for you?	Days (1-6) ☐	Weeks (1-3) ☐	Months (1-11) ☐	Years (1+) ☐	Unsure ☐

Referrer Information					
Referred by	Family Member ☐ Friend ☐ Partner ☐ External Agency ☐				
Referrer Name (family/friend/caseworker):					
Agency		**Phone**			
Mobile		**Fax**			
Email					
Has the young person previously accessed a headspace centre before?			Yes ☐	No ☐	Unsure ☐
Is the young person aware of this referral?			Yes ☐	No ☐	Unsure ☐
If under 16, are the parents/carers aware of this referral (and willing to respect and comply with headspace policies)?			Yes ☐	No ☐	Unsure ☐
Is the young person under the care of Territory Families or in alternative care arrangements (i.e. living away from home in foster care)?			Yes ☐	No ☐	Unsure ☐
Does the young person currently access any other services (e.g. DASA, Anglicare)?			Yes ☐	No ☐	Unsure ☐
Please Specify if 'Yes':					
Does the young person have any previous (or current) Mental Health Treatment Plans (MHTP)?			Yes ☐	No ☐	Unsure ☐
Please Specify Where/Who From if 'Yes':					
Please provide any relevant information/details of why the young person requires general practitioner, counselling or vocational support below from your understandings:					

Please return this completed form to our headspace Reception in person or by fax or email.