

# Referral to headspace

Date: \_\_\_\_\_

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

**If the young person is severely at risk or unwell, they may not be best suited to headspace – please contact the mental health hotline on 1800 011 511 (24hrs) for appropriate services, or take them to your nearest hospital**

Is this referral for **headspace** at Bathurst  OR Cowra

Is the young person aware of this referral? Yes  No  Unsure

If under 16 years, are their parents/carers aware? Yes  No  Unsure

Is the young person willing to attend headspace? Yes  No  Unsure

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 \_\_\_\_\_

**Relevant information (if you are a service, please attach any relevant assessments, reports, etc)**

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### Bathurst

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### Cowra

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