headspace Bondi Junction
Service Provider Referral Form

Ensure all sections are completed, UPPERCASE and legible

Fax to **9366 8888** or email to **headspacebondijunction@health.nsw.gov.au**

Our team are contactable during business hours on 9366 8800

Once a referral form has been received, a headspace staff member will make contact with the young person within 3 working days. This is an administrative call and is not a clinical assessment or therapeutic support.

You can use this form to provide additional information when a young person has already booked an initial appointment.

headspace Bondi Junction is NOT an acute mental health service.

If you have any immediate concerns for the safety of a young person, please call the Mental Health Line on 1800 011 511. Alternatively, direct the young person to the Emergency Department of their nearest hospital or call 000.

Referrer Details:			
Name of Referrer		**Organisation**	
Role			
Street Address			**Post Code:**
Phone		Fax	
Mobile			
Email			

Has the young person agreed to this referral?	Yes No	**If ' No' the referral cannot be accepted**
If the young person is under 16yrs, is their parent/carer/guardian aware of the referral?	Yes No	
Is this a referral or are you providing additional information to support a young person's engagement?	New Referral	Additional information for client file

Young Persons Details			
First Name		**Last Name**	
Preferred Name		**Gender**	
DOB		**Age**	
Street Address			**Post Code:**
Home Phone		Can we leave a message?	Yes No
Mobile Phone		Can we leave a message?	Yes No
Email			
Can we post letters to the above address?		Yes No Unknown	

Emergency Contact Details (Next of Kin)			
First Name		**Last Name**	
Relationship to Young Person			
Street Address		**Post Code:**	
Home Phone		Mobile Phone	
Can we contact the Next of Kin?		Yes No Emergency only	

Young Person's Medical Infomation	
Does the young person have their own GP?	Yes No
Details of GP Practice?	
Does the young person have a current mental health care plan?	Yes No

Reason for Referral
What is the main concern regarding this young person?

Services involved in the care of the young person (identify current or previous)

Current/previous risk factors

□ Suicide □ Self-harm □ Harm to others □ Domestic violence
□ Alcohol and drug use □ Homelessness □ Extreme Social Withdrawal □ Non-compliance

□ Mental Illness or disorder (previous diagnosis)

Please provide further details: e.g. recent suicidal thoughts, plans, symptoms, behaviours, concerns from others about risk, at risk mental state (depressed, despair, hopelessness, guilt, marked agitation, intoxication)