Young Persons Information

First Name(s): Surname:

Date of birth:

Address:

Email**:**

Best Contact Number:

How do you describe your gender? Your Pronouns:

Do you identify as Aboriginal and/or Torres Strait Islander?

Aboriginal Torres Strait Islander Both Neither

Do you identify as LGBTQIA+? Yes No Unsure

Do you require the services of an Interpreter? Yes No Unsure

*If yes, please provide details such as language and/or dialect*

Are you homeless or at risk of becoming homeless? Yes No Unsure

Do you have any communication or access needs? Yes No Unsure

*If yes, please provide details such as ramp access, larger font, assistive listening device, low sensory environment etc.*

**Why are you making this referral today - include all information that you feel would be beneficial for us to know about this referral.**

Medical Information

Is the name on your Medicare card the same as the name above? Yes No

If no, what is your legal name?

Medicare number: Ref no: (next to name)

Expiry: \_\_\_\_\_\_/\_\_\_\_\_\_\_

Do you have a GP or Specialist Doctor? Yes No

Doctor’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Practice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medical conditions you think we should be aware of:  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Details

Full name of emergency contact:   
(must be 18+)

Relation to you: Contact number:   
(e.g. parent, friend)

If you are under 16 years old, do you have a parent or legal guardian to provide consent for this service?  
Yes No Same as Emergency Contact person

*If yes:*Parent/Guardian full name: Contact number:

*Upon receiving of this referral, the young person will receive a* ***confirmation text message*** *from headspace Box Hill as an acknowledgement.*

If you wish to gain an update on the current waiting time, please contact us via 03 9810 9310

When a young person commences a service with headspace they are registered in hAPI and mandatory personal information is collected (first name, last name, date of birth, and suburb) to open an Episode of Care (EOC). By expressing an intent to engage in headspace services you are providing implied consent to record your personal information on our systems.

The data provided here will be used by headspace Box Hill to determine appropriate care. At this stage no written consent is required as we will not be sharing this personal data with anyone outside headspace. It is simply needed to create a profile in hAPI so we can track their journey with headspace. This information is confidential to the young person and the service providers supporting them.