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| Referral Form | | | Date: |
| There are a few ways you can contact headspace to make a referral. You are welcome to use the method that is comfortable and convenient for you. Which centre is your referral for?  (Please use bold to indicate your choice) | | | |
| headspace Chatswood  Call us on: 02 8021 3668  Fax this form to: 02 8021 7410  Return this form via email: info@headspacechatswood.org.au  Post this form to:  30 Devonshire Street Chatswood NSW 2067 | | headspace Brookvale  Call us on: 02 9937 6500  Fax this form to: 02 9938 3099  Return this form via email: info@headspacebrookvale.org.au  Post this form to:  Level 2 1A Cross Street Brookvale NSW 2100 | |
| Who is making the referral? (Please use bold to indicate your choice) | | | |
| The Young Person (Self-Referral) A Family Member A Friend  Other Please specify: | | | |
| Young Person’s Details | | | |
| Full Name: | | | |
| Preferred Name: | | | |
| Date of Birth: | | | |
| Gender: | Preferred Pronouns: | | |
| Phone Number: | | | |
| Email Address: | | | |
| Interpreter Needed: Yes/No Language Required: | | | |
| If you are NOT the Young Person being referred, please complete the following: | | | |
| Full Name: | | | |
| Relationship to Young Person: | | | |
| Phone Number: | | | |
| Has the young person given their consent for the referral? Yes/No  We need the consent of the young person before we can book them in for an appointment at headspace. If the young person hasn’t given their consent, or doesn’t know about the referral, we can still provide you with advice, information, and support. | | | |
| One of our Youth Access Clinicians will be in contact with you soon to discuss your referral.  We recognise that sometimes people need immediate help and support. If you need urgent assistance, please contact Kids Helpline on 1800 551 800, Lifeline on 13 11 14, the Mental Health Line on 1800 011 511, or attend your local hospital emergency department. | | | |