# headspace Referral Form

Please send the completed referral form via email or fax.
Email: headspacebundaberg@unitedsynergies.com.au
Fax: 4152 2602

## Referrer's Details

Organisation: _____

Contact Name: _____

Phone Number: _____

Address: _____

**Referral Type** (Please Tick):

☐ General Practitioner/ Health Care Provider

☐ Government Agency

☐ Other: _____

## Young Person's Details

Name: _____ Date of Birth: _____

Gender: ☐Female ☐Male ☐Non-Binary ☐Other Aboriginal and/or Torres Strait Islander: ☐Yes ☐No

Address: _____

**What are the young person's best contact details?**

Phone (home): _____

Phone (mobile): _____

**Can headspace leave a voicemail message when contact is attempted?** ☐ Yes ☐ No

**Has the young person consented to this referral?** ☐ Written ☐ Verbal

Please provide the relevant documentation with this form.

**Can a guardian or carer be contacted as well?** ☐ Yes ☐ No

Name: _____

Phone: _____

**What is the main reason for referral to headspace Bundaberg?**

☐ Mental Health

☐ Alcohol and Other Drugs

☐ Physical Health (Including sexual health)

☐ Vocation or Education

☐ Other

## Additional Information

_____

_____

_____

_____

_____

_____

_____

**Do you believe that this young person is currently at risk?** ☐ Yes ☐ No

**If yes, what are the known risks to self/others/staff?**

_____

_____

_____

**Please note:** We are not an emergency service. If the young person needs immediate assistance, please call the mental health care line 1300 MH CALL (1300 642 255) or report to the nearest hospital emergency department.

**66 Woongarra St**
**PO Box 925**
**Bundaberg, QLD, 4670**

**T: 07 4152 3931**
**F: 07 4152 6602**
**headspace.org.au/bundaberg**

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