headspace Referral Form

Please send the completed referral form via email or fax.
Email: headspacebundaberg@youturn.org.au
Fax: 4152 6602

Referrer Type (Please Tick)

- ☐ Self
- ☐ Parent/ Guardian/Friend
- ☐ GP/ Health Care Provider
- ☐ Other

Referrer Details

Contact name			
Phone		Fax	
Postal Address			
Email Address			
Organisation		Department	

Young Person Details

Name		Date of Birth		☐ Male ☐ Female ☐ Non-binary ☐_____
Aboriginal ☐ Yes ☐ No		Torres Strait Islander ☐ Yes ☐ No		
Address				
Medicare Number				

Contact details for: ☐ Young person or ☐ Parent/Guardian

Phone number		Email address	
Can headspace leave a voicemail on this phone number? ☐ Yes ☐ No			
Can headspace text this number? ☐ Yes ☐ No			
Can the parent/guardian be contacted regarding this referral? ☐ Yes ☐ No		Parent/Guardian name: _____ Contact number: _____	
Is the young person aware of this referral? ☐ Yes ☐ No		For young people under 16 years of age is the Parent/ Guardian aware of this referral? ☐ Yes ☐ No	
Does the young person consent for feedback to be given to the referrer? ☐ Yes ☐ No			

Reason for Referral

- ☐ Mental Health support
- ☐ Alcohol and other drugs support
- ☐ Education or employment Issue
- ☐ Physical or sexual health

Additional Information

Do you believe that this young person is currently at risk? ☐ Yes ☐ No
If yes, what are the known risks to themselves/others/staff?

Please note: We are not an emergency service. If the young person needs immediate assistance, please call 000 or report to the nearest hospital emergency department.