

# Referral/Registration Form

headspace Coffs Harbour is not a crisis service. headspace provides early intervention for young people aged 12 -25 years experiencing, or at risk of experiencing, mild to moderate mental health concerns.

For all immediate mental health concerns, please call: Mental Health Access Line: 1800 011 511 or Kids Helpline: 1800 551 800



This referral has not been accepted by headspace until we contact the young person and advise you accordingly

Date of referral: ___/___/___	Has the young person been a client at headspace Coffs Harbour before? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Has the young person agreed to this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No (consent of the young person is <b>required</b> )	
If the young person is under 16 years, are the parents/carers aware of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

Details of Young Person			
Name:		Preferred name:	
Date of birth: ___/___/___	Age: <input type="text"/>	Gender Identity:	Pronouns:
Address:			<input type="checkbox"/> Homeless
Phone:		If we can sms you your appointment reminders, tick here <input type="checkbox"/>	
Who should we contact to make appointments? <input type="checkbox"/> Young Person <input type="checkbox"/> Referrer <input type="checkbox"/> Parent/Caregiver Name: _____ Phone: _____ <input type="checkbox"/> Other Name: _____ Phone: _____		Country of Birth: _____ Language: _____	
Which phone number would you like your survey sent to? <input type="checkbox"/> Same as above or <input type="checkbox"/> Phone: _____			
Email:			
<b>This question is asked to help tailor your health needs.</b>			
Aboriginal or Torres Strait Islander (TSI): <input type="checkbox"/> Aboriginal <input type="checkbox"/> TSI <input type="checkbox"/> Both <input type="checkbox"/> Not Indigenous <input type="checkbox"/> Prefer not to say			
Main cultural background other than Australian or Aboriginal and/or Torres Strait Islander: _____			
Medicare Card No.	Ref No.	Valid to:	
Consent to Bulk Bill: YES/NO		Consent to EScripts YES/NO	
Health Care Card No.	Valid to:		

Emergency contact (in case we can't reach the young person)	
Name:	Relationship to young person:
Address:	
Phone:	

Details of Referrer (If you are completing this form for yourself you don't need to fill this in)	
Referred by (Name):	
Relationship:	Organisation:
Address:	
Phone:	Email/Fax:

Additional Supports		
Do you/the young person have a regular GP? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
GP Name and Practice details:		
Does the young person have a mental health care plan? <input type="checkbox"/> Yes (please attach) <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Is the young person engaged with any other services? Please click/tick	<input type="checkbox"/> School Counsellor	Name:
	<input type="checkbox"/> Psychiatrist	Name:
	<input type="checkbox"/> Psychologist	Name:
	<input type="checkbox"/> Paediatrician	Name:
	<input type="checkbox"/> NDIS or disability support	Name:
	<input type="checkbox"/> Housing	Name:
	<input type="checkbox"/> Dietitian	Name:
	<input type="checkbox"/> Other	Name:

Please describe the reasons for the referral below	Please list any medications
<input type="checkbox"/> Low mood	<input type="checkbox"/> None
<input type="checkbox"/> Anxious	<input type="checkbox"/>
<input type="checkbox"/> Issues with close relationships	<input type="checkbox"/>
<input type="checkbox"/> Grief/loss	<input type="checkbox"/>
<input type="checkbox"/> School avoidance	<input type="checkbox"/>
<input type="checkbox"/> Drugs and alcohol	<input type="checkbox"/>
<input type="checkbox"/> Work issues	<input type="checkbox"/>
<input type="checkbox"/> Sexual health	<input type="checkbox"/>
<input type="checkbox"/> Gender dysphoria	<input type="checkbox"/>
<input type="checkbox"/> Other:	

**Comments:**

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Type of service(s) needed, if known: Mental Health  Physical Health  Drug and Alcohol  Vocational Support  Sexual Health and Wellbeing  Other \_\_\_\_\_

Referrer Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Thank you for completing this referral. Please fax to 02 6652 7379 or email to [referrals@healthvoyage.org.au](mailto:referrals@healthvoyage.org.au).

If you have not heard from us within 7 working days please contact headspace on 02 6652 1878