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? ☐ Yes ☐ No ☐ Don't know
Has the young person agreed to this referral? ☐ Yes ☐ No (consent of the young person is **required**)	
If the young person is under 16 years, are the parents/carers aware of referral? ☐ Yes ☐ No ☐ N/A	

Details of Young Person			
Name:		Preferred name:	
Date of birth: ___ / ___ / _____	Age:	Gender Identity:	Pronouns:
Address:			☐ Homeless
Phone:		If we can sms you your appointment reminders, tick here ☐	
Who should we contact to make appointments? ☐ Young Person ☐ Referrer ☐ Parent/Caregiver Name: _____ Phone: _____ ☐ Other Name: _____ Phone: _____		Country of Birth: _____ Language: _____	
Which phone number would you like your survey sent to? ☐ Same as above or ☐ Phone: _____			
Email:			
Aboriginal or Torres Strait Islander (TSI): ☐ Aboriginal ☐ TSI ☐ Both ☐ Not Indigenous ☐ Prefer not to say			
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:

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

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

Comments:

_____

_____

_____

_____

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.

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

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