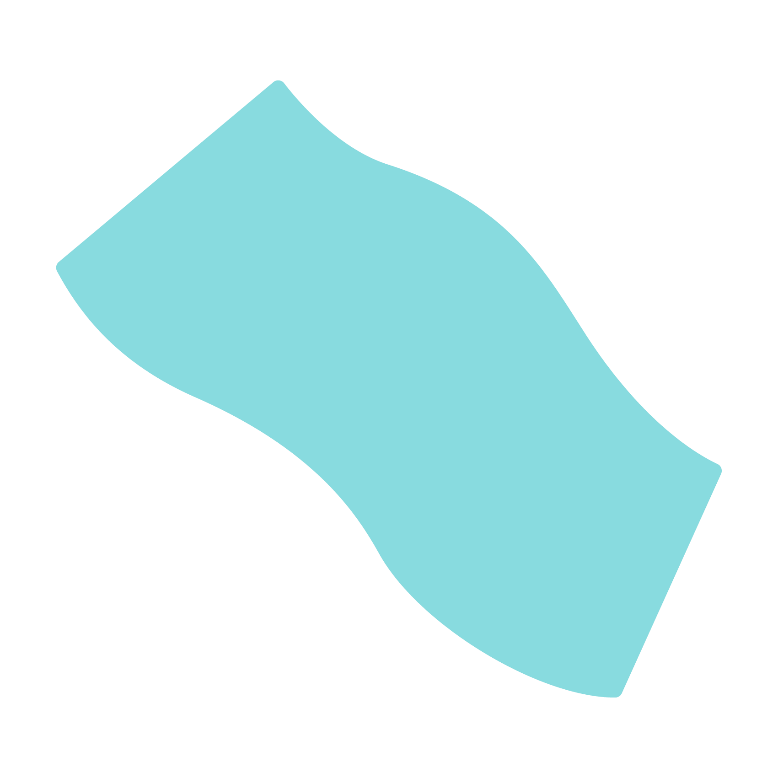
Referral/Registration Form

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.

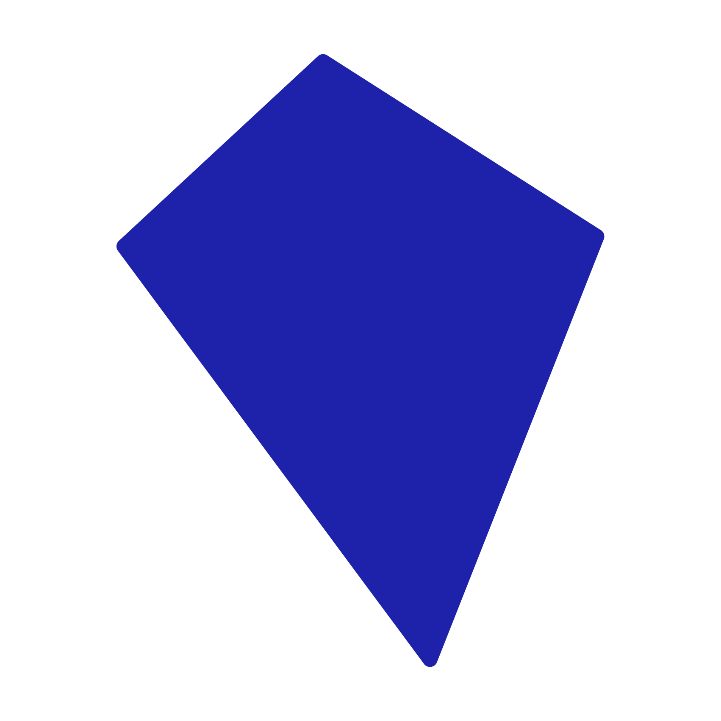
For all immediate mental health concerns, please call: Mental Health Access Line: 1800 011 511 or Kids Helpline: 1800 551 800

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



|  |  |
| --- | --- |
| **Date of referral:**  Click or tap to enter a date. | Has the young person been a client at headspace Coffs Harbour before? Yes No Don’t now |
| 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: Click or tap here to enter text. | | | Preferred name: Click or tap here to enter text. | |
| Date of birth: Click or tap to enter a date. | Age: | Gender Identity: Click or tap here to enter text. | | Pronouns: Click or tap here to enter text. |
| Address: Click or tap here to enter text. | | | | Homeless |
| Phone: Click or tap here to enter text. | | | If you consent to receive sms messages about your appointment reminders, tick here | |
| Who should we contact to make appointments? Country of Birth: Click or tap here to enter text.  Young Person Language: Click or tap here to enter text.  Referrer  Parent/Caregiver Name: Click or tap here to enter text. Phone: Click or tap here to enter text.  Other Name: Click or tap here to enter text. Phone: Click or tap here to enter text.  Which phone number would you like your survey sent to?  Same as above or  Phone: Click or tap here to enter text. | | | | |
| Email: Click or tap here to enter text. | | | | |
| Aboriginal or Torres Strait Islander (TSI):  Aboriginal  TSI  Both  Not Indigenous  Prefer not to say | | | | |



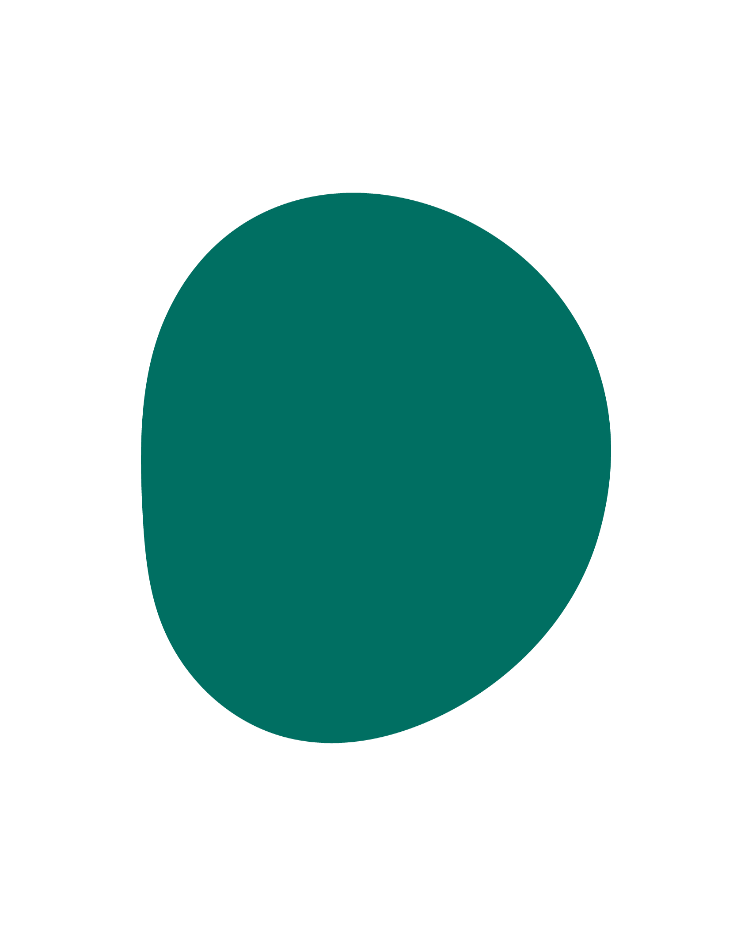
|  |  |
| --- | --- |
| **Details of Referrer (If you are completing this form for yourself you don’t need to fill this in)** | |
| Referred by (Name): Click or tap here to enter text. | |
| Relationship:Click or tap here to enter text. | Organisation:Click or tap here to enter text. |
| Address:Click or tap here to enter text. | |
| Phone: Click or tap here to enter text. | Email/Fax: Click or tap here to enter text. |

|  |  |
| --- | --- |
| **Emergency contact (in case we can’t reach the young person)** | |
| Name:Click or tap here to enter text. | Relationship to young person:  Click or tap here to enter text. |
| Address: Click or tap here to enter text. | |
| Phone: Click or tap here to enter text. | |

A yellow diamond shaped object

Description automatically generated

|  |  |  |
| --- | --- | --- |
| **Additional Supports** | | |
| **Do you/the young person have a regular GP?**  Yes  No  Unknown | | |
| GP Name and Practice details: Click or tap here to enter text. | | |
| Medicare Number: Click or tap here to enter text. Ref Number: Click or tap here to enter text. Valid to: Click or tap here to enter text. | | |
| 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: Click or tap here to enter text. |
| Psychiatrist | Name: Click or tap here to enter text. |
| Psychologist | Name: Click or tap here to enter text. |
| Paediatrician | Name: Click or tap here to enter text. |
| NDIS or disability support | Name: Click or tap here to enter text. |
| Housing | Name: Click or tap here to enter text. |
| Employment service | Name: Click or tap here to enter text. |
| Dietician | Name: Click or tap here to enter text. |
| Other | Name: Click or tap here to enter text. |



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| --- | --- |
| **Referral details: Please describe the reasons for the referral below** | |
| **Please click/tick the reasons for the referral** | Low mood  Anxious  Issues with close relationships  Grief/loss  School avoidance  Drugs and alcohol  Work issues  Sexual health  Gender Dysmorphia  Other: Click or tap here to enter text. |

|  |
| --- |
| **Comments:**Click or tap here to enter text. |

**Type of service(s) needed, if known.**

Mental Health  Physical Health  Drug and Alcohol  Vocational Support  Sexual Health and Wellbeing

Other Click or tap here to enter text.

**Referrer Name:** Click or tap here to enter text. **Signature:** Click or tap here to enter text. **Date:** Click or tap here to enter text.

**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