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



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| **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 |

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| **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 |



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| **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. |

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| **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. |



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| **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.  |

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| **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****.**

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