

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 required)			
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?		Country of Birth: _____		
<input type="checkbox"/> Young Person <input type="checkbox"/> Referrer <input type="checkbox"/> Parent/Caregiver Name: _____ <input type="checkbox"/> Other Name: _____		Language: _____ Phone: _____ Phone: _____		
Which phone number would you like your survey sent to? <input type="checkbox"/> Same as above or <input type="checkbox"/> Phone: _____				
Email:				
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				
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"/> DIS 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"/> Anxious <input type="checkbox"/> Issues with close relationships <input type="checkbox"/> Grief/loss <input type="checkbox"/> School avoidance <input type="checkbox"/> Drugs and alcohol <input type="checkbox"/> Work issues <input type="checkbox"/> Sexual health <input type="checkbox"/> Gender dysphoria <input type="checkbox"/> Other: _____	<input type="checkbox"/> None <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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.

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