Self-referral Form to headspace Devonport



headspace Devonport supports young people aged 12-25. It is not an acute mental health or crisis service. If you have concerns for your own or someone else's immediate safety please contact the Mental Health Helpline on: 1800 332 388. For urgent medical assistance please call: 000. By filling in this form you agree to attend all appointments at headspace Devonport.

If you are a service provider, please use the 'Professional Referral Form'

Please return completed form to one of the following:

- headspace Devonport, Level 1/35 Oldaker Street, Devonport
- headspace Devonport, PO Box 27, Devonport TAS 7310
 devonport@csys.com.au
 Fax (03) 6424 6102

- Phone us on (03) 6424 2144 if you have any questions

Your details

Full name:				
Preferred name:	Date of birth:	Date of birth:		
Gender:	Pronouns:			
Home address:				
Suburb:	Postcode:			
Postal address:				
Suburb:	Postcode:			
Email address:	,			
Home phone:	Mobile phone:			
What is the best way to contact you? Tick all that apply	☐ Home phone	☐ Mobile phone	☐ Email	
	☐ Letter	☐ Voicemail		
What are the best times to contact you?				
Can we use SMS to confirm your appointments?	☐ Yes	□No		
Can we send mail to your postal address?	☐ Yes	□No		
Are you Aboriginal or Torres Strait Islander?	☐ Yes	□No	☐ Both	
If born overseas, what country?				
What is your preferred language?				
Do you require an interpreter?	☐ Yes	□No		
Medicare number:	Ref:	Expiry date:		
Healthcare/Pension card number:		Expiry date:		
Are you an overseas visitor or student:	☐ Yes	□ No		
Health fund: Member name:		Expiry date:		

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Emergency contact or next of kin (must be over 18)

Full name:			
Relationship:	Phone number:		
Current support			
If you are under 16 do your parents/carers know about this referral?	☐ Yes	□No	
In the last 6 months have you received support from any other mental health services? CAMHS, ACMHS, Anglicare etc	☐ Yes If yes, please lis	□ No t	
Do you have a current Mental Health Care Plan?	☐ Yes	□No	
Do you have an NDIS Plan?	Yes	□No	
Are you under any legal or guardianship orders?	☐ Yes	□No	
Do you have a regular doctor?	Yes	□No	
	Name:		
What kind of support would you like? You o	an pick more tha	an one	
□ Doctor □ Nurse □ Coun	selling/Mental Health ☐ Education or work		
☐ Alcohol and/or drug use ☐ Impacted by Hillcre	est Primary Schoo	I incident	Other - detail
In your own words, please tell us why you would like t	o speak to someo	ne at heads	pace Devonport
Support to fill in form			
Has someone helped you to fill in this form? Would you like us to make contact with them about	Ll Yes	Ll No	
this referral?	☐ Yes	□ No	
Their full name:			
Relationship:	Phone number:		
Email address:			
We are not able to accept referrals without the welcome to contact our Acces			

Privacy, confidentiality and how we use your information: Please read, sign and return the privacy information sheet.

What happens next? We will attempt to make contact with you within 2 working days to chat to you about your referral. Please add our phone number, 6424 2144, into your contacts so you know who is calling you. If we are not able to get in contact with you, we will follow up with an SMS, email or letter.