Referral to headspace Dubbo

Date:

Young Persons Details:

Name: _____
Date of Birth: _____
Address: _____
Contact Phone Number: _____
☐Young Person ☐Parent/Carer ☐Other:_____
Identify as Aboriginal and/or Torres Strait Islander?:
Aboriginal ☐ Torres Strait Islander ☐ Both ☐
Require interpreter services? Yes ☐ No ☐

Consent:

Is the young person aware of this referral? Yes☐ No☐
If under 16 years, are the parents/carers aware? Yes☐ No☐
Has an appointment already been made by phone? Yes☐ No☐
If yes, indicate date and time of appointment: _____
Does the young person provide consent for feedback to be given to the referrer? Yes □ No □

Reason for referral:

☐Mental Health
☐Physical Health
☐Drug and Alcohol
☐Vocational
☐Other

Do you believe this young person is currently at risk of harm to themselves or other people?
☐Yes (please comment):_____
☐No

Relevant Information:

_____
_____
_____
_____

Referrer Details:

Contact Name:_____
Organisation: _____
Postal Address: _____
Contact Phone Number: _____ Mobile: _____Fax: _____
Email: _____
If referring from school will 'in-school appointment' via phone/telehealth in a private space be possible?
☐Yes (phone or telehealth? please specify): _____
☐No

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