

Referral to headspace Dubbo

Date: _____

Young Person's Details:

Name: _____

Preferred Name: _____

Pronouns: _____

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

Consent: Require interpreter services? Yes No

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's 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