

Referral Form

Date: _____

Young Person's Details

Full Name: _____

Address: _____

Postal Address (if different): _____

DOB: ____/____/____ Current Age: _____ Female Male Other

Do you identify as being Aboriginal? Yes No

Do you identify as being Torres Strait Islander? Yes No

Do you identify as being Aboriginal and Torres Strait Islander? Yes No

Phone number: _____

Email Address: _____

*Please note: we must have at least two ways that we can contact you

Preferred Contact Person and Phone number (for appointments only):

Name: _____ Relationship to young person _____

Phone number: _____

Services I am interested in:

Mental Health Services Drug and Alcohol

Doctor (all appointments bulk billed with a current Medicare card) Vocational/Educational/Job Seeking

Other: _____

Please outline your reasons for referring:

Service access information:

Do you have a GP? Yes No _____
Are you linked with any other services? Yes No _____
Do you have a counsellor? Yes No _____
Have you accessed any counselling sessions anywhere else this calendar year? Yes No

Risk:

Have you deliberately harmed yourself? Yes No
Have you been admitted to hospital in the last 30 days for mental health? Yes No
Have you thought of ending your life? Yes No
*If yes to any of the above - **ACCESSLINE** must be advised. Yes No

Referrer's Details:

Has the young person consented to this referral being made? Yes No
If the young person is under the age of 14, have the person's parents or carers given consent? Yes No

Referrer's name: _____

Organisation: _____

Relationship to client: _____

Postal Address: _____

Phone number: _____

Email address: _____

*Please note: We will liaise with the client from this point, unless consent is provided from the client.

How to submit this form:

In Person: Drop into our centre at 1/26 Ulong Street Griffith
Tel: 02 6962 3277
Fax: 02 6962 6925
Email: headspacegriffith@mphn.org.au
Mail: PO Box 1067 Griffith NSW 2680

Please note: headspace Griffith is not a crisis service

For any immediate concerns please call

Accessline on 1800 800 944

Available 24 hours a day

Office use only: Referral entered Referral scanned Client allocated and Date _____

Numbers provided: Accessline 1800 800 944 Lifeline 13 11 14 Kids Helpline 1800 55 1800