This headspace Mackay program is supported by funding from the Australian Government under the PHN Program.

Self, Family and Friends Referral Form

Date of referral: / /

Given Name: _____

Surname: _____

Address: _____

_____

Post Code_____

Phone: _____

Sex: Male ❒ Female ❒

DOB: / / Age: _____

Indigenous Status

Aboriginal/Torres Strait Islander:

Yes ❒ No ❒

Current Living Environment:

Live Alone ❒

Home with Parents ❒

Home with Care Giver ❒

Other (eg Crisis Accommodation) ❒

Contact person/carer details

Name: _____

Telephone: _____

Relationship: _____

Has the client or person responsible consented to this referral?

Yes ❒ No ❒

Reason for referral:

Counselling Services ❒

Social / Activity Groups ❒

Are there any known risks to self/others/staff?

No ❒ Make Intake apt

Yes ❒ Put phone call through to Intake (or any other clinician/CL if Intake not available) If nobody available, give them CYMHS or CMH number and then get intake to call back when available.

Referrer details:

Name: _____

Organisation: _____

Position: _____

Phone: _____

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