Headspace Referral Form

Referral Date: **Entered By:**

Please note: **headspace** is a service for young people between the ages of 12 to 25. We are a voluntary service who engage with young people and their families.
headspace is not a crisis/ acute mental health service. If the young person is at high or acute risk of suicide or harm to self or others, please contact their GP, emergency services on 000 or Rural & Remote Emergency Mental Health Service (24hrs) on 13 14 65.

Young Person's Details

Full Name: _____ Previous client? yes ☐ no ☐ unk ☐

Date of Birth: _____ Age: _____ Gender: Male ☐ Female ☐ Non-Binary ☐ Transgender ☐

Client Address: _____

Contact Number*(s)*: _____ Email: _____

Aboriginal or Torres Strait Islander? Yes ☐ No ☐ Country of Birth _____

Client's Key Contact Person *(in case of emergency)*

Name: _____ Relationship to young person: _____

Contact Number(s): _____

Address: _____

Referrer's Details *Please tick if self-referring*: ☐

Referrer Full Name: _____

Contact Number: _____ Email Address: _____

Workplace: _____

Job Title: _____

☐ If adding more documentation to this referral, please tick this box

Reason for Referral *(What is the main reason the young person is seeking help?)*

_____

_____

_____

_____

_____

headspace GP appointment only ☐ (please tick) **Medicare No:** _____ **Ref:** ____ **Expiry:** _____

GP Information

Does the young person have an existing GP? Yes ☐ No ☐ *(If yes, please fill in the details below)*

Doctor's Name: _____

Practice Name: _____ Phone:_____

Consent **Client is aware of referral and has given consent: Yes ☐ No ☐**

******PRIVACY******

If the young person does not want their parents or carers to know about them accessing our services, please let us know and we will note this on their file.(*Young people aged **under 16** years need to have a responsible adult to provide consent*)

Doesn't Mind ☐ Keep Private ☐