**Referral Form**

*Please ensure you have read and understood the attached* ***headspace*** *Osborne Park Referral Guidelines prior to completing this referral. Please forward completed referral to either* *info@headspaceospk.com.au**, fax to (08) 9208 9599, post to PO Box 498, Osborne Park, WA, 6917 or hand deliver to Suite 2/145 Main Street, in Osborne Park.*

***Please follow up with a phone-call to ensure receipt of faxed referral.***

|  |  |
| --- | --- |
| **Date of Referral:**  | **Young Person consented to referral?** □ Yes □ No |
| ***Please note: Referrals will not be accepted without the signed consent of the young person.*** |
| **Young Person’s Details** |
| Name:  | DOB: | Gender: □ Male □ Female |
|
| Address:  | Preferred Contact *(e.g. phone, mobile, email, post)*: |
|
| Name of NOK/Emergency Contact: | Relationship: |
| Contact Phone: |
| Indigenous/Cultural Identity |   |
| **Referrer Details:** |
| Name:  | Organisation and Position: |
|
| Address:  | Email:  |
| Phone:  | Fax:  |
| **Reason/s For Referral** |
| (P*lease include here any information which may be useful as background information to assist with the referral e.g. Mental Health, Drug and Alcohol, Vocational/Educational, Physical Health, including past/current risk assessments).* *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
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| **Does the young person have an existing GP?** If yes, please provide details below. | □ Yes  | □ No  |  □ As Above  |
|
| Name:  | Surgery/Practice/Clinic: |
|
| Address:  | Email:  |
| Phone:  | Fax:  |
| **Can we contact them?** | □ Yes  | □ No  |  □ Unsure  |
|
| **Does the young person have an existing GP Mental Health Treatment Plan?** If yes, please attach necessary details. | □ Yes  | □ No  | □ Recommended  |
|
| **Is the young person linked in with any other services?** | If yes, please provide details:  |
|

**Please complete consent form overleaf.**

**Consent to Referral**

The **headspace** Osborne Park Referral Form collects information to assist **headspace** Osborne Park staff to help young people get access to the services they need as quickly as possible.

All information will be treated confidentially and will not be used for any other purposes than what is stated on our confidentiality statement and consent form (signed when the young person arrives for their appointment).

* I am aware that this referral is being made. I understand that I can withdraw from

this referral or from the referred service at any time.

* I consent to **headspace** Osborne Park obtaining relevant information from government and community-based agencies, doctors and other allied health professionals, specifically relevant to my care whilst being a client of **headspace** Osborne Park

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_

If the young person is under 16 years of age, authorisation should (where possible) also be provided by a parent/guardian/carer.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_