

headspace Osborne Park

Referral Form

Please sign and submit the completed form to info@headspaceospk.com.au or fax to 9208 9599
 Referrals will not be accepted without the signed consent of the young person (see overleaf)

| | | | |
|---|---------------------------------|-------------------------------------|--|
| Name of young person | | Date of Referral ___/___/___ | |
| Gender | | D.O.B. ___/___/___ | |
| Preferred Pronouns | | | |
| Is the young person of Aboriginal and or Torres Strait Islander descent? (tick as appropriate) | | | |
| No | Yes, Aboriginal | Yes, Torres Strait Islander | Yes, Aboriginal and Torres Strait Islander |
| Address | Street name: _____ | | |
| | Suburb: _____ Postcode: _____ | | |
| Contact details | Mobile: _____ Home Phone: _____ | | |
| | Email: _____ | | |
| Preferred contact | Mobile | Home Phone | Email Post |
| Next of Kin/Emergency contact name | | | Relationship |
| | | | Phone |
| GP name | | | Practice Name |
| GP contact details | Phone: _____ | | Email: _____ |
| Can we contact the GP? | Yes | No | Unsure |

| | | |
|--|--------------|-------------------------|
| Referrer name (if different to the GP) | | Referring Agency |
| Position | | |
| | Email | |
| | | Phone |
| Reason for referral (including mental health or drug and alcohol history / previous treatment, physical health, vocational/ educational) | | |
| Risk taking behaviours (self-harm, suicide ideation, substance use, aggression, self-neglect) | | |
| Involvement with other agencies / services (if yes, please provide details) | | |
| Relevant medical details (please attach an existing GP Mental Health Treatment Plan if applicable) | | |

BINDING MARGIN – NO WRITING

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CONSENT TO REFERRAL

This referral has been discussed with the young person who has agreed to the referral to headspace and sharing of information related to referral

Young Person

Signature: _____

Date: ___/___/_____

Print Name: _____

Young Person's parent or caregiver (required if the young person is under 16 years of age)

Signature: _____

Date: ___/___/_____

Print Name: _____

Relationship: _____

Referrer

Signature: _____

Date: ___/___/_____

Print Name: _____

Office use only

Confirmation sent by (name) _____ on (date) ___/___/_____

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