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)

BINDING MARGIN – NO WRITING

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)			

t: 08 9208 9555 **f:** 08 9208 9599 **e**: info@headspaceospk.com.au
Service location: Black Swan Health (Lead agency for headspace Osborne Park)
290 Scarborough Beach Rd Osborne Park, WA 6017
headspace National Youth Mental Health Foundation is funded by the Australian Govenment Department of Health

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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) ___/ _____/ _____

BINDING MARGIN – NO WRITING