headspace Port Adelaide
Referral Form

Fax to (08) 8312 3025 or email to
headspaceportadelaide@centacare.org.au

Date:

Young Person's Details (Young person knows about & agrees to referral: ☐ Yes)

Name: ______________________ Address: ______________________

DOB: ______________________ Phone: ______________________

Gender: ______________________ Email: ______________________

Preferred mode of contact: ☐ SMS ☐ Phone call ☐ Email ☐ Letter

Young Person's Language & Culture

Tick any that apply: ☐ Aboriginal ☐ Torres Strait Islander ☐ Culturally and Linguistically Diverse

Does the young person require an interpreter? ☐ No ☐ Yes, [language – including Auslan]: ______________

Reason(s) for Referral (tick all that apply)

☐ Mental health support

☐ Physical health support

☐ Alcohol and other drugs support

☐ Work & study support

☐ Financial counselling

Emergency Contact

Name: ______________________ Phone: ______________________

Relationship to young person: ______________________________________

Referrer Details

Name: ______________________ Role: ______________________

Agency: ______________________ Phone: ______________________

Email: ______________________ Fax: ______________________

Please note that **headspace** Port Adelaide is not a crisis service. Crisis care can be accessed via Western CAMHS (<16) on (08) 8161 7000 or Mental Health Triage (>16) on 13 14 65.

Consent

I, ____________________ [carer's name if young person under 16, young person's name if 16 or over], give consent for this referral to be made and give permission for ____________________ [referrer name] to exchange information with **headspace** Port Adelaide for the purpose of this referral.

Young person/carer signature: ______________________ Date: ______________________