Referral Form

Please ensure you have read and understood the attached headspace Rockhampton Referral Guidelines prior to completing this referral.

Please forward completed referral by fax to **(07) 4994 2538**
Email: HeadspaceIntake@headspacerockhampton.com.au
or hand deliver to 155 Alma St, Rockhampton

Client Information

First Name:

Surname:

D.O.B:

Phone: Home:

Mobile:

Residential Address:

Street: _____

Suburb: _____Postcode:_____

Email Address:

Medicare Card Number: _____ IRN_____ Expiry_____/_____

Preferred Contact Method ☐ Phone ☐ Text ☐ Post ☐ Email

Do you consent to receiving appointment reminder text: Please circle Yes / No

Do you have a Mental Health Care Plan from your GP: Please circle Yes / No

Indigenous/Cultural Identity

☐ Aboriginal
☐ Torres Strait Islander
☐ Aboriginal and Torres Strait Islander
☐ None ☐ Other:_____

Gender Identity

☐ Male
☐ Female
☐ Transgender
☐ Non-Binary
☐ Other: _____

Next of Kin / Emergency Contact

First Name: Surname:

Address:

Relationship

Phone:

2nd Contact

First Name: Surname:

Address:

Relationship:

Phone:

Referrer / GP Details

☐ Self-Referral

First Name: Surname:

Agency/Practice Name:

Phone: Fax: GP Provider Number:

Address:

Email address

Reason/s For Service

☐ Mental Health
- ☐ Anxiety
- ☐ Depression
- ☐ Self Harm
- ☐ Thoughts of Suicide
- ☐ Immediate Risk – Please call 000 / Ambulance, Police
  Acute Care Team (ACT) 1300 64 22 55

☐ Drug and Alcohol

☐ Physical Health

☐ Vocational/Educational

☐ Other _____

*Please provide details and information which may be useful, including background information and information about the reason/s for seeking the services of **headspace**.*

Consent:

*Please note that to accept this referral we require consent of the young person or parent if under the age of 16. If this is not possible please seek the advice of **headspace** clinical staff.*

Young Person

I am aware of and consent to this referral being made.
I understand that I can withdraw from this referral or from the referred service at any time.

Signed	Print Name	Date

Parent / Guardian / Carer

If the young person is under 16 years of age,
*Authorisation should (where possible) **also** be provided.*

Signed	Print Name	Date

Referrer / GP / Health Professional

Signed	Print Name	Date