

headspace Referral Form

Referral Date: _____ Entered By (office use only): _____

Please note: headspace is a service for young people between the **ages of 12 to 25** and their families.

We will always seek your consent to be involved in our services. If you are under 16 years, the consent of a legal guardian is generally required, and if you are over 16 you can consent for yourself.

headspace is not a crisis / acute mental health service.

If the young person is at high or acute risk of suicide or harm to self or others, please contact their GP, emergency services on 000, Lifeline 13 11 14 or Rural & Remote Emergency Mental Health Service on 13 14 65.

Young Person's Details

Full Name: _____	Previous Client? ☐ Yes ☐ No ☐ unknown	
Preferred name: _____	Date of Birth: _____	Age: _____
Client Address: _____		
Contact Number(s): _____	Email: _____	
Sex: ☐ Female ☐ Male ☐ Other	Pronouns: _____	
Gender: ☐ Female ☐ Male	Sexual orientation: _____	
☐ Gender diverse, please specify: _____		

Aboriginal and / or Torres Strait Islander? ☐ Both ☐ Aboriginal ☐ Torres Strait Islander	Mob: _____
Country of Birth: _____	Ethnicity / Cultural identity: _____
Do you require an interpreter? ☐ Yes ☐ No If yes, what language are you most comfortable speaking: _____	

Client's Key Contact Person (a person over the age of 18 in case of emergency)

Name: _____	Relationship to young person: _____
Contact Number(s): _____	

Referrer's Details

☐ Please tick if self-referring	
Full Name: _____	
Contact number: _____	Email Address: _____

Additional information for professional referrers

Workplace: _____
Job title: _____
☐ If adding more documentation to this referral, please tick this box

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Reason for Referral

What is the main reason the young person is seeking help?

☐ Mental health support
 ☐ Physical health / sexual health
 ☐ Alcohol & Other Drug support
 ☐ Work and Study

GP appointment only ☐ (please tick)
 Medicare No: _____
 Ref: _____
 Expiry: _____

GP Information

Does the young person have an existing GP? ☐ Yes ☐ No
 If yes, please fill in the details below

Doctor's Name: _____ Phone: _____

Practice Name: _____

Consent

Young person is aware of referral and has given consent: ☐ Yes ☐ No

If young person is under 16, has the legal guardian consented to the referral? ☐ Yes ☐ No

If no, please provide a reason: _____

Resources

For immediate support

Emergency Services 000 (112 on mobile)

Rural & Remote Emergency
Mental Health (24 hours) 13 14 65

eheadspace (3pm - 10pm) 1800 650 890 or
eheadspace.org.au

Child and Adolescent Virtual
Urgent Care Service www.wch.sa.go.au/patients-
visitors/emergencies/virtual-
urgent-care

Suicide Call Back Service 1300 659 467

Kids Helpline 1800 55 1800

For additional services and supports while you wait follow the QR code

