headspace Woodville Referral Form

GPs to complete Mental Health Treatment Plan
Please fax or email referral on F: 08 8345 1773
E: headspacewoodville@centacare.org.au

DATE of REFERRAL: / /

Young Person Details

Name:	**D.O.B.:**	**Gender:**
Address:	**Contact Number:**	**Email Address:**

Is the young person aware of the referral? Yes ☐ No ☐

Has the young person consented to the referral? Yes ☐ No ☐

If under 16, is the parent or caregiver aware of the referral? Yes ☐ No ☐

Cultural background: ☐ Aboriginal ☐ Torres Strait Islander ☐ Culturally and Linguistically Diverse ☐ N/A

Best method of contact: SMS ☐ Email ☐ Letter ☐ Mobile ☐

Emergency Contact

Name:	**Contact Number:**

Referrer Details

Name:	**Contact Number:**
Organisation:	**Contact Fax Number:**
Email Address:	**Relationship to Young Person:**

Reason for Referral

- ☐ Mental Health Support
- ☐ Drug and Alcohol Support
- ☐ Education and Vocational Support
- ☐ Other:

Please note: Medium to high risk young people may not be appropriate for this service.
Emergency mental health services can be contacted by calling 8161 7000 (under 18) or 13 14 65 (over 18)

Young Person and Carer Consent For Referral and Information

I (young person) _____ , being 16 years or older, agree to be referred to **headspace** Woodville and give my permission for (referrer's name) _____ to exchange information with **headspace** Woodville for the purpose of this referral

I (carer) _____ agree for (young person) _____ to be referred to **headspace** Woodville and for information to be shared as above.

Young person signature: Date:

Referrer/Carer signature: Date:

Office Use Only Referral Completed by: Face to Face Intake Booked:
Penelope ☐