**GP Referral to headspace Canberra**

**170 Haydon Drive, Building 18, Level B, University of Canberra, BRUCE, ACT 2601**

**p: 02 6201 5343 | f: 02 6201 2345 | e:** [info@headspacecanberra.org.au](mailto:info@headspacecanberra.org.au)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Details of Young Person** | | | Today’s Date: | |
| Name: | | | Preferred name: | |
| Gender:  Male  Female  Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date of Birth: | |
| Address: | | | | |
| Suburb: | | Postcode: | | |
| Phone (home): | | Phone (mobile): | | |
| Email: | | | | |
| Is the young person aware of this referral to headspace? Yes  No | | | | |
| If the young person is under 16 years, are the parents/carers aware of referral? Yes  No | | | | |
| Which contact/s would the young person prefer us to use? Home  Mobile  Email | | | | |
| Can we use SMS to confirm appointments? Yes  No | | | | |
| Medicare #: | | Reference #: | | Exp date: |
| **Details of Referrer** | | | | |
| Name: | Surgery: | | | |
| Address: | | | | Postcode: |
| Phone: | Fax: | | | |
| Email: | | | | |
| Is a Mental Health Care Plan attached? Yes  No | | | | |
| Are you or another person from the referring practice prepared to have continued involvement with the young person?  Yes  No  Name: Phone: | | | | |
| **Details of Referral** | | | | |
| Reason for referral: Mental Health   Needs assessment  Drug and Alcohol  Vocational  Other (please state) | | | | |
| Was the young person referred to you by someone else? Yes  No | | | | |
| If yes, who referred the young person to you? | | Name: | | |
| Service: | | Phone: | | |