Street Shop 9, 15 Central Avenue, Pialba, QLD, 4655
T 07 4303 2100 **F** 07 4303 2150 **E** headspace.fax@wmq.org.au
headspace.org.au/herveybay

Date of Referral:		**Is client aware of referral?**	☐ Yes ☐ No	**Is client willing to attend**	☐ Yes ☐ No
Referral Type:	☐Walk in ☐Phone ☐Email ☐ Fax	**Referral Source:**	☐Self ☐Doctor: ____________________ ☐School ☐Friend/Family Member ☐Service Provider:________________		

Client Details			
Name:		**Date of Birth:**	
Address:		**Place of Birth:**	
Suburb:		**Post Code:**	
Gender:	☐ Male ☐ Gender Diverse ☐ Unsure ☐ Female		
LGBTIQ+:	☐ Lesbian ☐ Gay ☐ Bisexual ☐ Trans ☐ Intersex ☐ Queer ☐ Straight ☐ Other		
Home Ph #		**Mobile Ph #**	
Ethnicity:		**Religion/Spirituality:**	
Health Care Card	**No:**	**Expiry**:	
Medicare	**No:**	**Reference:**	**Expiry:**
Do you suffer from any of the following health conditions?			
☐ Diabetes ☐ Heart Disease ☐ Epilepsy ☐ Lung Disease ☐ Kidney Disease ☐ Arthritis ☐ Asthma ☐ Low/high Blood Pressure ☐ Other: ________________________________			
Allergies:			

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Street Shop 9, 15 Central Avenue, Pialba, QLD, 4655
T 07 4303 2100 **F** 07 4303 2150 **E** headspace.fax@wmq.org.au
headspace.org.au/herveybay

<table>
<tr><td>Reason/s for Referral:</td><td colspan="5">☐ Mental Health ☐ Drugs and Alcohol ☐ School/Work ☐ General Health
☐ Homeless / At Risk of Homeless</td></tr>
<tr><td colspan="6"></td></tr>
<tr><th colspan="6">Parent/Guardian Contact Details</th></tr>
<tr><td>Name:</td><td></td><td>Phone:</td><td colspan="3"></td></tr>
<tr><td>Address:</td><td></td><td>Email:</td><td colspan="3"></td></tr>
<tr><td>Relationship:</td><td></td><td colspan="2">Can we contact this person about your appointments?</td><td colspan="2">☐ Yes ☐ No</td></tr>
<tr><th colspan="6">Parent/Guardian Contact Details</th></tr>
<tr><td>Name:</td><td></td><td>Phone:</td><td colspan="3"></td></tr>
<tr><td>Address:</td><td></td><td>Email:</td><td colspan="3"></td></tr>
<tr><td>Relationship:</td><td></td><td colspan="2">Can we contact this person about your appointments?</td><td colspan="2">☐ Yes ☐ No</td></tr>
<tr><th colspan="6">GP/Psychiatrist/Counsellor Contact Details</th></tr>
<tr><td>Name:</td><td></td><td>Phone:</td><td colspan="3"></td></tr>
<tr><td>Address:</td><td></td><td>Email:</td><td colspan="3"></td></tr>
<tr><td>Organisation:</td><td colspan="5"></td></tr>
<tr><th colspan="6">Referrer’s Details</th></tr>
<tr><td colspan="6">Referrer’s Details: ☐ Same details as Emergency Contact</td></tr>
<tr><td>Name:</td><td colspan="2"></td><td>Relationship:</td><td colspan="2"></td></tr>
<tr><td>Address:</td><td colspan="2"></td><td>Organisation:</td><td colspan="2"></td></tr>
<tr><td>Phone:</td><td></td><td>Email:</td><td colspan="3"></td></tr>
</table>

PLEASE COMPLETE BOTH SIDES OF THIS FORM