headspace Maroochydore Referral Form

REFERRAL TYPE (Please Tick):

☐Self
☐Guardian/ Parent
☐GP/ Health Care Provider
☐Government Agency
☐Other

REFERRER'S DETAILS

Organisation	
Contact Name	
Phone Number	
Address	

YOUNG PERSON'S DETAILS

Name		**Date of Birth**		M ☐ F ☐
Address				
Medicare Number		**Does the young person identify as Aboriginal and/or Torres Strait Islander?** Yes ☐No☐		
School Attending				

Best way to contact the young person	Home:	Mobile:	Text ☐ & / or Call ☐
	Email address:		
Consent from young person for headspace to text?	Yes☐ No☐	**Can headspace leave a message with the young person or another person when contact is made?** Yes ☐ No ☐	
Is the young person aware of this referral?	Yes☐ No☐	**Does the young person consent for feedback to be given to the referrer?** Yes ☐ No☐	
For young people under 16 years of age is the Parent/Guardian aware of this referral?	Yes☐ No☐	**Can the Parent/Guardian be contacted?** Yes ☐ No☐ **Name & Phone number**	

Reason for Referral?

☐Mental Health Issue ☐Drug & Alcohol Issue ☐Physical Health Issue ☐Education Issues ☐Employment Issues

Does the young person require a referral to the GP? Yes ☐ No ☐

Additional information:

Do you believe that this young person is currently at risk? Yes ☐ No ☐
If yes, what are the known risks to self/others/staff?

For Office Use Only:

Intake & Access Worker's Name:_____ Entered into Best Practice: Yes ☐ No☐

Date of Intake: _____ Time of Intake: _____

Follow Up Required: □ Y □ N hsmintake@unitedsynergies.com.au