COMMUNITY REFERRAL FORM

Referral criteria: 12 -25 years old for early intervention service. This is not an acute service.

Please provide the following information and fax to 4437 1399 or email to reception@headspacemtisa.org.au or drop into 1 / 2 West Street or phone us 4437 1300.

Date of Referral	_____ / _____ / ______	Tick Time Preferred: ☐ 9am – 12pm ☐ 1.30pm – 4pm ☐ 2.30pm & 3.30pm
Have you been here before?	☐ No ☐ Yes	
Referral Type:	☐ Walk in ☐ Phone ☐ e-Referral ☐ Email ☐ Fax	
Referral Source:	☐ Self ☐ Friend/Family ☐ Other service (*please specify*) _______________ ☐ School ☐ Clinical ☐ Other (*Please specify*) ___________________	

Client Details Below:			
Full Name:			
Date Of Birth:			
Gender:	☐ Male ☐ Female ☐ Intersex ☐Transgender ☐ Other_________________		
Ethnicity:	☐ Aboriginal ☐ Torres Strait Islander ☐ Australian Caucasian ☐ Other: Please specify _____________________________		
Address:			
Phone:		Mobile:	

Referrer's Details Below:			
Full Name:			
Relationship to Client:			
Address:			
Best Contact No.			
Email address:			
Organisation(if applicable):		Fax No:	

headspace National Youth Mental Health Foundation is funded by the Australian Government Department of Health

COMMUNITY REFERRAL FORM

Reason/s for Referrals:
(*Please circle one or more from below)* Clinical – Mental Health Drug and Alcohol School/Work General Health Individual Placement & Support/Employment In house group programs Physiotherapy / Dietitian / Exercise Physiology / Speech Pathology Mental Health Nurse
Is the client linked with other services? ☐ YES ☐ NO If "Yes", please provide details: ___________________________________

How did you find out about this service (please circle)?				
Family/Friends	Internet	Community Service	Radio	Health Professional
Newspaper	School/Uni/TAFE	Other Services	Presentations	GP
TV	Walked Past	Pamphlets	Psychiatrist	Event: ______________
Other: ______________				

Client Consent:			
This referral must be discussed with the client. headspace Mount Isa is unable to contact them without their consent.			
Do you have the client's consent for this referral? *(Please have the client sign below)*		☐ Yes	☐ No
If under 14 years of age, are the parents/carers aware of this referral?		☐ Yes	☐ No
Client signature:	____________________________________	Date:	_______
Referrer's signature:	____________________________________	Date:	_______

headspace staff: Create file in BP ☐ Upload to BP Correspondence In ☐ Enter into Intake List ☐ Create hapi

headspace National Youth Mental Health Foundation is funded by the Australian Government Department of Health