

Referral Form

Referral criteria: 12-25 years old, early intervention. headspace Kununurra may support young people by referring them to other services where appropriate. headspace Kununurra is not a crisis service.

Young person's details

First name:		Last name:	
Preferred name:			
Date of Birth:		Pronouns:	
Address:			
Suburb:		Postcode:	
Phone #:	Preferred contact: <input type="checkbox"/> SMS <input type="checkbox"/> Phone <input type="checkbox"/> Email		
Email Address:			
Preferred Person to Contact:			
Contact's number or email:			
Does the young person identify as:	<input type="checkbox"/> Aboriginal	<input type="checkbox"/> TSI	<input type="checkbox"/> Both <input type="checkbox"/> Other
Medicare #	Reference #	Expiry:	
Healthcare card?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Card #	

Guardian's details

(if young person is under 16 years of age, a guardian must be listed)

Full Name:	
Relationship to Young Person:	
Phone Number:	
Can we contact this person if the young person is unavailable?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Referrer's details

Full Name:	
Organisation:	
Role title:	
Phone Number:	Fax Number:
Email:	

Reason for referral and relevant history

Please attach any relevant assessment notes, discharge summaries, and/or additional information

Current supports

Are you aware of the young person currently/previously accessing any of the following supports?

- | | | |
|--|---|---|
| <input type="checkbox"/> General Practitioner Services | <input type="checkbox"/> Public Mental Health Service | <input type="checkbox"/> Employment Services |
| <input type="checkbox"/> Private Practitioner | <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Drug and Alcohol |
| <input type="checkbox"/> Homelessness Provider | <input type="checkbox"/> Child Protection Agency | <input type="checkbox"/> Juvenile Justice/Corrections |
| <input type="checkbox"/> Other Please specify: | | |

What service is the young person hoping to access at headspace Kununurra?

- Physical/sexual health AOD Vocational/educational Mental health/counselling

(More than one option may be selected)

Authorisation of referral by young person

Does the young person consent to this referral being made? Yes No

Date:

The young person must be aware of the referral and provide their consent for headspace Kununurra to accept the referral.

A headspace Kununurra staff member will attempt to contact the young person within 48 hours (excluding weekends) of the referral being received. The referrer will be notified once a referral has been received by headspace Kununurra.

If you have any questions please contact headspace Kununurra via phone on 08 9166 5797

Doctors please note: *If the young person has completed a **Mental Health Treatment plan (2715 or 2717)**, please attach a copy of plan.*

Email: headspacer referral@wunanhealth.org.au
Ph: 08 9166 5797
144 Konkerberry Drive, Kununurra, WA, 6743