

Office Only
Date received: _____
Date Allocated: _____
Worker allocated: _____

Referral Form (external agencies)

Date sent: _____

Name: _____ DOB: _____

Address: _____

Phone: _____ Mobile: _____

Email: _____ Client Consent Given: _____

Best time to contact and method: _____

Please tick service/s you are referring for:

- | | | | | | |
|----------------|--------------------------|----------------|--------------------------|--------------------|--------------------------|
| Mental Health | <input type="checkbox"/> | General Health | <input type="checkbox"/> | GP Services | <input type="checkbox"/> |
| Drug & Alcohol | <input type="checkbox"/> | Sexual Health | <input type="checkbox"/> | Mental Health Plan | <input type="checkbox"/> |
| Counselling | <input type="checkbox"/> | Chronic Health | <input type="checkbox"/> | | |

Reason for referral (please be as specific as possible)

Current Risk factors: (Please note any that may be relevant)

Suicide risk (if high risk refer initially to mental health services)

- | | | | |
|------------------------|--------------------------|-----------------------|--------------------------|
| History of Aggression: | <input type="checkbox"/> | Homelessness: | <input type="checkbox"/> |
| Substance Abuse: | <input type="checkbox"/> | Deliberate self harm: | <input type="checkbox"/> |
| Forensic History: | <input type="checkbox"/> | Other: | _____ |

Referral Agency/Service:	_____
Workers Name:	_____
Phone:	_____ Fax: _____
Email:	_____
Other agencies involved with the young person:	_____

Please send all referrals to attention Intake headspace fax 6336 4490 or PO Box 7513, Launceston or email headspace@gpnorth.com.au