

Referral Form

Please fax to (02) 6652 7379 or email to referrals@genhealth.org.au

headspace Coffs Harbour is not a crisis service.

For all immediate support, please call the **Mental Health Access Line: 1800 011 511**

We provide early intervention for young people aged 12 – 25 years experiencing mild to moderate mental health concerns

Referrals will be reviewed within 5 working days and the preferred contact person will be called. Please complete as much of this form as you can. We can help fill out any missing information when we contact you.

Date of referral	Has the young person	n been a client at headspace Coffs Harbour before?
	☐ Yes ☐ No ☐	Don't know
Has the young person agreed t	to this referral? Yes No (consent of the young person is required)
If the young person is under 16	years, are the parents/carers awa	re of referral? Yes No N/A
Details of Young Person		
Name:		Preferred name:
Date of Birth:	Age:	Sex at birth
Gender identity (optional)		
Address:		☐ Homeless
Phone:		Can we use SMS for appointment
Filone.		reminders? Yes No
	se to arrange appointments for this	
	act number and relationship to you	ng
person		
Email:		
Aboriginal or Torres Strait Islan	ider (TSI): 🔲 Aboriginal 🔲 TSI	☐ Both ☐ Not Indigenous

Emergency contact (in case we can't reac	h the young person)		
Name:	Relationship to young person:		
Address:			
Phone:			
Details of Referrer- If you are completing t	this form for yourself you don't need to fill this in		
Referred by (Name):			
Relationship:	Organisation:		
Address:			
Phone:	Fax:		
Email:			
Additional Supports			
Does the young person have a regular GP? Yes	s No Unknown		
GP Name and Practice details:			
Does the young person have a mental health care pla	n?		
Is the young person engaged with any other service.g., school counsellor, psychiatrist, paediatrician,	ces?		
disability support, housing, employment service etc.)			
Referral details: Please describe the reason for example, low mood, anxious, issues with close relationships issues, physical and or sexual health issues	ons for the referral below ionships, grief/loss, school avoidance, drug and alcohol, work		
Type of service(s) needed, if known: ☐ Mental Health ☐ Physical Health ☐ Drug and Alco	ohol 🗌 Vocational Support 🔲 Sexual Health and Wellbeing		
Other Thank you for	completing this referral		

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