Referral to headspace

Date: _____

Do you believe this young person is currently at risk of harm to themselves or other people? Yes ☐ No ☐

If the young person is severely at risk or unwell, they may not be best suited to headspace – please contact the mental health hotline on 1800 011 511 (24hrs) for appropriate services, or take them to your nearest hospital

Is this referral for **headspace** at Bathurst ☐ OR Cowra ☐

Is the young person aware of this referral? Yes ☐ No ☐ Unsure ☐

If under 16 years, are their parents/carers aware? Yes ☐ No ☐ Unsure ☐

Is the young person willing to attend headspace? Yes ☐ No ☐ Unsure ☐

Does the young person provide consent for feedback to be given to the referrer? Yes ☐ No ☐

Client name: _____ Client DOB: _____

Client Address: _____

Contact Phone Number: _____ (whose phone, ie young person, mum) _____

Referred by:

Contact Name:_____ Organisation: _____

Ph: _____ Mobile: _____

Email: _____ Fax: _____

Postal Address: _____

Reason for referral:

☐ Mental Health ☐ Physical Health ☐ Drug and Alcohol ☐ Vocational ☐ Other _____

Relevant information (if you are a service, please attach any relevant assessments, reports, etc)

_____

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