Date of Referral:

|  |  |  |
| --- | --- | --- |
| **Name:**  | **D.O.B.:**  | **Gender:**  |
| **Address:**  | **Contact Number:**  | **Email Address:**  |

**Young Person Details**  *If under 16, is the parent or caregiver aware of the referral?* Yes [ ]  No [ ]  *Cultural background:* Aboriginal [ ]  Torres Strait Islander [ ]  Culturally and Linguistically Diverse [ ]  *Best method of contact:* SMS [ ]  Email [ ]  Letter [ ]  Mobile [ ]

**Emergency Contact**

|  |  |
| --- | --- |
| **Name:**  | **Contact Number:**  |

 **Referrer Details**

|  |  |
| --- | --- |
| **Name:**  | **Contact Number:**  |
| **Organisation:**  | **Contact Fax Number:**  |
| **Email Address:**  | **Relationship to Young Person:**  |

 **Reason for Referral**Please provide us with some information about the main reason for referring this young person.
If you are concerned with this person’s risk towards themselves or others, please identify how.

 **Please note: Medium to high risk young people may not be appropriate for this service.
Emergency mental health services can be contacted by calling 8161 7000 (under 16) or 13 14 65 (over 16)**

**Young Person and Carer Consent For Referral and Information**
I (young person) , being 16 years or older, agree to be referred to **headspace**
Onkaparinga and give my permission for (referrer’s name) to exchange information with **headspace** Onkaparinga for the purpose of this referralI (carer) agree for (young person) to be referred
to **headspace** Onkaparinga and for information to be shared as above.

Young person signature Date

Referrer/Carer signature Date