

# headspace Joondalup

## Referral Form



Please sign and submit the completed form to [info@headspacejoondalup.com.au](mailto:info@headspacejoondalup.com.au) or fax to 9301 0859  
Referrals will not be accepted without the signed consent of the young person (see overleaf)

<b>Name of young person</b>		<b>Date of Referral</b>
<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<b>D.O.B.</b>
<b>Is the young person of Aboriginal and or Torres Strait Islander descent?</b> (tick as appropriate) <input type="checkbox"/> No <input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander		
<b>Address</b>	Street name: _____ Suburb: _____ Postcode: _____	
<b>Contact details</b>	Mobile: _____ Home Phone: _____ Email: _____	
<b>Preferred contact</b>	<input type="checkbox"/> Mobile <input type="checkbox"/> Home Phone <input type="checkbox"/> Email <input type="checkbox"/> Post	
<b>Next of Kin/Emergency contact name</b>		<b>Relationship</b>
		<b>Phone</b>
<b>GP name</b>		<b>Practice Name</b>
<b>GP contact details</b>	Phone: _____	Email: _____
<b>Can we contact the GP?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	

<b>Referrer name</b> (if different to the GP)		<b>Referring Agency</b>
<b>Position</b>		<b>Email</b>
		<b>Phone</b>
<b>Reason for referral</b> (including mental health or drug and alcohol history / previous treatment, physical health, vocational/ educational)		
<b>Risk taking behaviours</b> (self-harm, suicide ideation, substance use, aggression, self-neglect)		
<b>Involvement with other agencies / services</b> (if yes, please provide details)		
<b>Relevant medical details</b> (please attach an existing GP Mental Health Treatment Plan if applicable)		

BINDING MARGIN – NO WRITING

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### CONSENT TO REFERRAL

*This referral has been discussed with the young person who has agreed to the referral to **headspace** and sharing of information related to referral*

#### Young Person

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

#### Young Person's parent or caregiver (required if the young person is under 16 years of age)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

#### Referrer

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

#### Office use only

Confirmation sent by (name) \_\_\_\_\_ on (date) \_\_\_ / \_\_\_ / \_\_\_\_\_

BINDING MARGIN – NO WRITING