headspace Osborne Park

headspace Osborne Park Referral Form

Please sign and submit the completed form to info@headspaceospk.com.au or fax to 9G€Ì ÁJÍ JJ
Referrals will not be accepted without the signed consent of the young person (see overleaf)

Name of young person		**Date of Referral** ___ / ___ / _____
Gender	☐ Male ☐ Female ☐ ____________________	**D.O.B.** ___ / ___ / _____
Is the young person of Aboriginal and or Torres Strait Islander descent? (tick as appropriate) ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander		
Address	Street name: ____ Suburb: ______________________________ Postcode: ____________	
Contact details	Mobile: ______________________ Home Phone: _________________ Email: __________________________________	
Preferred contact	☐ Mobile ☐ Home Phone ☐ Email ☐ Post	
Next of Kin/Emergency contact name		**Relationship** **Phone**
GP name		**Practice Name**
GP contact details	Phone: _____________________	Email: ______________________
Can we contact the GP?	☐ Yes ☐ No ☐ Unsure	

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

BINDING MARGIN – NO WRITING

t: 08 9208 9555 **f:** 08 9208 9599 **e**: info@headspaceospk.com.au
Service location: Black Swan Health (lead agency for headspace Osborne Park)
145 Main Street, Osborne Park, WA 6017

headspace National Youth Mental Health Foundation is funded by the Australian Government Department of Health

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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