gp referral form

1-3, 1 Torrens St, BRADDON, ACT 2612
p: 02 5109 9700
e: hs.canberra@marathonhealth.com.au
healthlink: hdspcanb

Details of Young Person			Today's Date:
Name:			Preferred name:
Gender: Male ☐ Female ☐ Other ☐ ____________			Date of Birth:
Address:			
Suburb:	Postcode:		
Phone (home):	Phone (mobile):		
Email:			
Is the young person aware of this referral to headspace? Yes ☐ No ☐			
If the young person is under 16 years, are the parents/carers aware of referral? Yes ☐ No ☐			
Which contact/s would the young person prefer us to use? Home ☐ Mobile ☐ Email ☐			
Can we use SMS to confirm appointments? Yes ☐ No ☐			
Medicare #:	Reference #:	Exp date:	
Details of Referrer			
Name:	Surgery:		
Address:		Postcode:	
Phone:	Fax:		
Email:			
Is a Mental Health Care Plan attached? Yes ☐ No ☐			
Are you or another person from the referring practice prepared to have continued involvement with the young person? Yes ☐ No ☐ Name: Phone:			
Details of Referral			
Reason for referral: Mental Health ☐ Needs assessment ☐ Drug and Alcohol ☐ Vocational ☐ Other (please state) ☐			
Was the young person referred to you by someone else? Yes ☐ No ☐			

If yes, who referred the young person to you?	Name:
Service:	Phone: