

Referral to headspace Canberra

Unit 1/1 Torrens Street Braddon ACT 2612
P 02 6113 5700

Return to headspace Canberra by Fax (02 6113 5744) or Email (info@headspaceCanberra.org.au)

headspace Canberra is not a crisis service. If you have any immediate concerns for the safety of a young person, please call:

Access Mental Health Team: **1800 629 354**
Lifeline: **13 11 14**
In an emergency, contact **000** immediately.

Details of Young Person

Today's Date:

First Name:	Last Name:	Preferred name:
Gender (optional):	Date of Birth:	
Address:		
Contact number:	SMS consent? Yes <input type="checkbox"/> No <input type="checkbox"/>	Email:
Medicare #:	Reference #:	Exp date:

Consent

headspace is a voluntary service; referrals will not be accepted without the consent of the young person.

Has the young person agreed to this referral? Yes No

Does the young person have a Mental Health Treatment Plan? Yes No

If the young person is under 16 years, is a legal guardian aware of referral? Yes No 16 or over

Guardian's name:	Guardian's contact number:
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Details of Referrer

Name:	Service:	
Address:		
Phone:	Fax:	Email:
Will you or another person from your service have continued involvement with the young person?		
Yes <input type="checkbox"/> No <input type="checkbox"/>	Name:	Phone:
Does the young person currently receive support from any other services?		
Yes <input type="checkbox"/> No <input type="checkbox"/>	Name:	Phone:

Primary reason for referral: Mental Health Drug and Alcohol Vocational Other _____

What are some of the current issues? *(please include info about duration, age of onset and pre-existing diagnoses):*

What has been the impact of these? *(e.g. relationships, school, work, home etc.):*

What are the young person's goals and objectives?

Is the young person currently supported by other health services? *(If so, please provide service details below)* Yes No

Does the young person consent to headspace Canberra exchanging information with these services to support this referral? *(If so, please provide contact details below)* Yes No

Signature of Referrer: _____ **Signature of Young Person:** _____

Please note: If you are emailing this form to headspace Canberra, encrypt where possible. Please be aware that all forms of written communication involve an element of risk that information could be read by someone other than the intended recipient.