External Agency Referral

headspace Alice Springs

Date			

General Information			
First Name		**Last Name**	
Alias / Skin Name / Preferred Name (i.e. Kuminljai)			
DOB		**Gender**	☐Female ☐Male ☐ Gender Diverse ☐Indeterminate ☐Other
Sexuality	☐Heterosexual (Straight) ☐Lesbian ☐Gay ☐Bisexual ☐Other Sexuality (i.e. Queer, Pansexual, etc.) ☐Questioning ☐Choose not to answer		
Please specify if 'Other':			
Relationship Status	☐Single/Never Married ☐In a relationship/Married/De Facto ☐Divorced ☐Separated ☐Widowed ☐Choose not to answer		
Indigenous?	☐No ☐Aboriginal ☐Torres Strait Islander ☐Aboriginal and Torres Strait Islander ☐Choose not to answer		
Ethnicity (other than Aboriginal and/or Torres Strait Islander)			
Country of Birth		**Town of Birth**	
If not Australian, year of arrival?			
Main Language Spoken at Home		**Other Languages**	

Contact Details					
Address					
Town		**State**		**Postcode**	
Mobile Number					
Email					

5/74 Todd St
Alice Springs NT 0870
headspace.org.au/alicesprings

T 08 8958 4544
F 08 7906 2244
E: headspace.reception@caac.org.au

headspace National Youth Mental Health Foundation is funded by the Australian Government Department of Health
ABN 26 137 533 843

Emergency Contact Details			
Name		**Relationship**	
Mobile Number			
Next of Kin Details (If not the same as Emergency Contact Details)			
Name		**Relationship**	
Mobile Number			

Health Care Card Information					
Medicare Number		**Reference Number**		**Expiry**	
(If applicable) Centrelink Health Care Card Number	Click or tap here to enter text.			**Expiry**	

Service Information	
What support would you like to access? (Tick more than one if applicable)	☐Doctor ☐Psychologist/Mental Health Counselling ☐Work/Vocational Support ☐AOD

Please tick which boxes below apply to you for relevant information relating to why you are accessing our youth service:

☐Feeling Sad or Depressed	☐Sexual Health	☐Doctor Check Up
☐Feeling Anxious	☐Sexuality Confusion/Questioning	☐Anger and Aggression
☐Concerned Sleeping	☐Gender Confusion/Questioning	☐Bullying
☐Concerned Eating	☐Living Situation	☐Stress
☐Self Esteem/Body Image	☐Work and Study	☐Loneliness
☐Relationship Issues	☐Disruptive Thoughts	☐Nightmares
☐Substance Abuse (Alcohol/Drugs)	**Other:** Click or tap here to enter text.	
☐Financial Situation		

How long has/have this/these been an issue for you?	☐Days (1-6) ☐Weeks (1-3) ☐Months (1-11) ☐Years (1+) ☐Unsure

Referrer Information			
Referrer Name:			
Referrer Position Title:	☐Case Manager ☐Support Worker ☐Aboriginal Liaison Officer ☐Other:_____		
Agency		**Phone**	
Mobile		**Fax**	
Email			

Has the young person previously accessed a headspace centre before?	☐Yes ☐No ☐Unsure
Is the young person aware of this referral?	☐Yes ☐No ☐Unsure
If under 16, are the parents/carers aware of this referral (and willing to respect and comply with headspace policies)?	☐Yes ☐No ☐Unsure
Is the young person under the care of Territory Families or in alternative care arrangements (i.e. living away from home in foster care)?	☐Yes ☐No ☐Unsure
Does the young person currently access any other services (e.g. DASA, Anglicare)?	☐Yes ☐No ☐Unsure
Please Specify if 'Yes':	
Does the young person have any previous (or current) Mental Health Treatment Plans (MHTP)?	☐Yes ☐No ☐Unsure
Please Specify Where/Who From if 'Yes':	

Please provide any relevant information/details of why the young person requires general practitioner, counselling or vocational support below from your understandings:

Please return this completed form to our headspace Reception in person or by fax or email.