Referral Form

headspace Batemans Bay

Date: _____

Young person's details:

Full Name: _____

Address: _____

Postal Address (If different): _____

DOB: _____ Current Age: _____ Gender: _____

Do you identify as being Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

Phone Number: _____

Email Address: _____

Preferred Contact Person and Phone Number (for appointments only):

_____

Services I am interested in:

- ☐ Mental Health Support
- ☐ Drug and Alcohol
- ☐ GP
- ☐ Dietician
- ☐ Vocational/Education/Job Seeking
- ☐ Other: _____

Please specify the main reason for seeking help:

Service access information:

Do you have an existing GP?	☐ Yes	☐ No	_____
Are you linked with any other services?	☐ Yes	☐ No	_____
Do you have an existing counsellor?	☐ Yes	☐ No	_____
Do you have an existing MHTP?	☐ Yes	☐ No	_____
Have you accessed any FPS sessions this calendar year?	☐ Yes	☐ No	_____

Risk:

Have you deliberately harmed yourself? ☐ Yes ☐ No

Have you been admitted to the hospital in the last 30 days for Mental Health? ☐ Yes ☐ No

Have you thought of ending your life? ☐ Yes ☐ No

*If yes to any of the above – Mental Health Line must be advised of. ☐ Yes ☐ No

Referrer's details:

- ☐ Has the young person consented to this referral being made?
- ☐ If the young person is under the age of 14, have the person's parents or carers given consent?

Name: _____

Organisation: _____

Relationship to Client: _____

Postal Address: _____

Phone Number: _____

Email Address: _____

*Please Note; we will continue to liaise with the client from this point, unless consent is provided from the client.

How to submit this form:

Fax: (02) 9169 3478

Email: info@headspacebatemansbay.org.au

Please note: This service is not a crisis service.

For any immediate concerns please call Mental Health Line on 1800 011 511

This is a 24 hour telephone service.

Office Use Only: ☐ Referral Entered ☐ Referral Scanned ☐ Client Allocated & Date: _____