

**Referral to headspace Dubbo**

**Date:**

**Young Persons Details:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🗆 Young Person 🗆 Parent/Carer 🗆 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identify as Aboriginal and/or Torres Strait Islander?:

Aboriginal 🗆 Torres Strait Islander 🗆 Both 🗆

Require interpreter services? Yes 🗆 No 🗆

**Consent:**

Is the young person aware of this referral? Yes 🗆 No 🗆

If under 16 years, are the parents/carers aware? Yes 🗆 No 🗆

Has an appointment already been made by phone? Yes 🗆 No 🗆

If yes, indicate date and time of appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Does the young person provide consent for feedback to be given to the referrer? Yes 🗆 No 🗆

**Reason for referral:**

🗆 Mental Health

🗆 Physical Health

🗆 Drug and Alcohol

🗆 Vocational

🗆 Other

Do you believe this young person is currently at risk of harm to themselves or other people?

🗆 Yes (please comment):

🗆 No

**Relevant Information:**

**Referrer Details:**

Contact Name:

Organisation:

Postal Address:

Contact Phone Number: Mobile: Fax:

Email:

**headspace Dubbo**

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