headspace Joondalup
Referral Form

Please sign and submit the completed form to info@headspacejoondalup.com.au or fax to 9301 0859
Referrals will not be accepted without the signed consent of the young person (see overleaf)

Name of young person		**Date of Referral** ___ / ___ / _____
Gender	☐ Male ☐ Female ☐ Other	**D.O.B.** ___ / ___ / _____
Is the young person of Aboriginal and or Torres Strait Islander descent? (tick as appropriate) ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander		
Address	Street name: _____ Suburb: _____ Postcode: _____	
Contact details	Mobile: _____ Home Phone: _____ Email: _____	
Preferred contact	☐ Mobile ☐ Home Phone ☐ Email ☐ Post	
Next of Kin/Emergency contact name		**Relationship** **Phone**
GP name		**Practice Name**
GP contact details	Phone: _____	Email: _____
Can we contact the GP?	☐ Yes ☐ No ☐ Unsure	

Referrer name (if different to the GP)		**Referring Agency**
Position		**Email** **Phone**
Reason for referral (including mental health or drug and alcohol history / previous treatment, physical health, vocational/ educational)		
Risk taking behaviours (self-harm, suicide ideation, substance use, aggression, self-neglect)		
Involvement with other agencies / services (if yes, please provide details)		
Relevant medical details (please attach an existing GP Mental Health Treatment Plan if applicable)		

BINDING MARGIN – NO WRITING

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CONSENT TO REFERRAL

*This referral has been discussed with the young person who has agreed to the referral to **headspace** and sharing of information related to referral*

Young Person

Signature: _____ Date: ___ / ___ / _____

Print Name: _____

Young Person's parent or caregiver (required if the young person is under 16 years of age)

Signature: _____ Date: ___ / ___ / _____

Print Name: _____ **Relationship**: _____

Referrer

Signature: _____ Date: ___ / ___ / _____

Print Name: _____

Office use only

Confirmation sent by (name) _____ on (date) ___ / _____ / _____

BINDING MARGIN – NO WRITING