headspace Bunbury Referral Form

Date: / /	Referred By	
Organisation:		
Referrer Contact Number	Ph.	Fax.

YOUNG PERSON DETAILS

Name:	DOB: / /
Address:	Phone number:
	Medicare No: Position: Expiry:
Parent/Carer Name (if applicable):	
Parent/Carer Contact Number (if applicable): Young Person Consent to contact Parent/Carer to arrange appointments? Yes ☐ No ☐	

Doctor:	Provider number:
Existing Mental Health Care Plan: Yes / No Date created: / / **(If there is an existing Mental Health Care Plan please attach to this referral)**	
Services Required: Mental Health Support ☐ Drug & Alcohol Support: ☐ Vocational Support: ☐ Sexual Health Advice: ☐	Reason for referral: **(Please include all relevant history and attach separate sheet if required)**

I am aware and consent to this referral and give headspace Bunbury permission to contact me or my parent/carer to arrange appointments.

Name: _____ Signature: _____ Date: ____/_____/_____

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