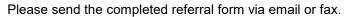
headspace Referral Form



Email: headspacebundaberg@youturn.org.au

Fax: 4152 6602

$\sqrt{2}$	headspace Bundaberg
GO	Bundaberg

Referrer Type (Please Tick)		Referrer Details						
□ Self		Contact name						
□ Parent/ Guardian/Friend		Phone		Fax				
☐ GP/ Health Care Provider		Postal Address						
□ Other		Email Address	ail Address					
		Organisation			Depa	rtment		
Young Person Det	tails							
Name			Date of Birth			∕lale □	Female □ Non-b	oinary
Aboriginal □ Yes	□ No		Torres	rres Strait Islander □ Yes □ No				
Address								
Medicare Number								
Contact details for	r: □ Young perso	on or □ Parent/Guard		ail address				
	yo o voicemail or	this phone number?						
Can headspace tex		this phone number?	_ res	□ No				
			ol2 Por	ont/Guardian r	namo:			
Can the parent/guardian be contacted regarding this referral? ☐ Yes ☐ No				Parent/Guardian name: Contact number:				
Is the young person aware of this referral? ☐ Yes ☐ No			For	For young people under 16 years of age is the Parent/ Guardian aware of this referral? Yes No				
	rson consent for f	eedback to be given to				ui: 🗆 i		
Reason for Referr Mental Health su Alcohol and othe	pport r drugs support	□ Education	•	•				
Additional Informa	ation							
Do you believe that this young person is currently at risk? ☐ Yes ☐ No If yes, what are the known risks to themselves/others/staff?								

Please note: We are not an emergency service. If the young person needs immediate assistance, please call 000 or report to the nearest hospital emergency department.