Young Person/Carer Self-Referral Registration Form

Full Name: _____ **Previous client?** Yes ☐ No ☐ Unknown ☐

Date of Birth: _____ **Age:** _____ **Gender:** Male ☐ Female ☐ Non binary ☐ TransGender ☐

Client Address: _____

Contact Number(s): _____ **Email:** _____

Centrelink Status: Unemployment Benefit ☐ Disability Support Pension ☐ Youth Allowance ☐ Student ☐ No Benefits ☐ Other *(please specify)* ☐ _____

Aboriginal or Torres Strait Islander? Yes ☐ No ☐ **Country of Birth** _____

Client's Key Contact Person *(in case of emergency)* **Name**: _____

Relationship to young person: _____ Phone: _____

Referrer's Details **Please tick if referring self** ☐

Referrer Full Name: _____ Contact Number: _____

Email Address: _____

Relationship to young person: _____

Is the young person involved in any Legal Issues? Yes ☐ No ☐

Reason for Referral? *(What is the main problem that the young person is seeking help with?)*

A clinician will call to gain further information about this

_____

_____

_____

_____

_____

_____

Does the young person have an existing GP? Yes ☐ No ☐ If yes, Doctor's Name: _____

Practice Name: _____ Phone: _____

Consent and Privacy

The young person is aware of the referral and wants to attend headspace Yes ☐ No ☐

Privacy:

If the young person does not want their parents or carers to know about them accessing our services, please let us know and we will note this on their file. **Doesn't Mind** ☐ **Keep Private** ☐

(Note: Young people aged *16 years and under need to have a responsible adult involved*)

OFFICE USE ONLY

Referral Received by:

Date and Time _____

Entered to Mastercare by _____