

Referral Form

Please send the completed referral form via email or fax.

Email: headspacebundaberg@youturn.org.au

Fax: 4152 6602

Eligibility Criteria

- Young people between 12 and 25
- Young people not in acute crisis, nor currently suicidal.

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.

*Required field

Young Person's Legal Name*: _____

Young Person's Preferred Name: _____

Date of Birth*: _____ Aboriginal and/or Torres Strait Islander: Yes No

Gender: Female Male Non-Binary Other

Client's Address: _____

Suburb: _____ State: _____ Postcode: _____

Contact Number*: _____ Is this number the young person's? Yes No

If No - Contact's Name: _____ Relationship to young person: _____

Medicare Number: _____ Position on Card: ____ Expiry: _____

Health Care Card: Yes No- Number: _____ Expiry: _____

Referral Reasons

- | | |
|---|--|
| <input type="checkbox"/> General Practitioner Support | <input type="checkbox"/> Vocation or Educational Support |
| <input type="checkbox"/> Mental Health Support | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Alcohol and Other Drug Support | |

Please provide any relevant details about this referral

Name of Referrer: _____

Organisation: _____

Contact Number: _____