GP Referral to headspace Canberra

1-3, 1 Torrens St, BRADDON, ACT 2612
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Details of Young Person	Today's Date:
Name:	Preferred name:
Gender: Male ☐ Female ☐ Other ☐ _____	Date of Birth:
Address:	
Suburb:	Postcode:
Phone (home):	Phone (mobile):
Email:	
Is the young person aware of this referral to headspace? Yes ☐ No ☐	
If the young person is under 16 years, are the parents/carers aware of referral? Yes ☐ No ☐	
Which contact/s would the young person prefer us to use? Home ☐ Mobile ☐ Email ☐	
Can we use SMS to confirm appointments? Yes ☐ No ☐	
Medicare #:	Reference #: Exp date:
Details of Referrer	
Name:	Surgery:
Address:	Postcode:
Phone:	Fax:
Email:	
Is a Mental Health Care Plan attached? Yes ☐ No ☐	
Are you or another person from the referring practice prepared to have continued involvement with the young person? Yes ☐ No ☐ Name: Phone:	
Details of Referral	
Reason for referral: Mental Health ☐ Needs assessment ☐ Drug and Alcohol ☐ Vocational ☐ Other (please state) ☐	
Was the young person referred to you by someone else? Yes ☐ No ☐	
If yes, who referred the young person to you?	Name:
Service:	Phone: