**GP Referral to headspace Canberra**

**170 Haydon Drive, Building 18, Level B, University of Canberra, BRUCE, ACT 2601**

**p: 02 6201 5343 | f: 02 6201 2345 | e:** info@headspacecanberra.org.au

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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: |