headspace Onkaparinga Community Referral Form

GPs to complete Mental Health Treatment Plan
Please fax referral to **headspace** Onkaparinga on 08 8186 8699

Date of Referral:

Young Person Details

Name:	**D.O.B.:**	**Gender:**
Address:	**Contact Number:**	**Email Address:**

If under 16, is the parent or caregiver aware of the referral? Yes ☐ No ☐

Cultural background: Aboriginal ☐ Torres Strait Islander ☐ Culturally and Linguistically Diverse ☐

Best method of contact: SMS ☐ Email ☐ Letter ☐ Mobile ☐

Emergency Contact

Name:	**Contact Number:**

Referrer Details

Name:	**Contact Number:**
Organisation:	**Contact Fax Number:**
Email Address:	**Relationship to Young Person:**

Reason for Referral

Please provide us with some information about the main reason for referring this young person.
If you are concerned with this person's risk towards themselves or others, please identify how.

Please note: Medium to high risk young people may not be appropriate for this service.
Emergency mental health services can be contacted by calling 8161 7000 (under 16) or 13 14 65 (over 16)

Young Person and Carer Consent For Referral and Information

I (young person) _____ , being 16 years or older, agree to be referred to **headspace** Onkaparinga and give my permission for (referrer's name) _____ to exchange information with **headspace** Onkaparinga for the purpose of this referral

I (carer) _____ agree for (young person) _____ to be referred to **headspace** Onkaparinga and for information to be shared as above.

Young person signature Date

Referrer/Carer signature Date

Office Use Only Referral Completed by: Appointment Booked:
Review / /