headspace Rockhampton Registration Form

Please complete as much of this form as possible.
If you would like help completing it, please ask and we will assist you.

Young Person's details:					
Full Name:					
Preferred Name:		**Date of Birth:**		**Age:**	
Gender:		**Ethnicity:**			
Residential Address:	**Street Address:** **Suburb:** **Postcode:**				
Postal Address: *(if different)*	**Street Address:** **Suburb:** **Postcode:**				
Contact Number:		**Email:**			
If we need to contact you at this address or phone number, are there any precautions needed? Please specify:					
Can we send you an SMS reminder for any future appointments?	☐ Yes ☐ No				
Do you wish to be part of our email list to hear about upcoming groups and events?	☐ Yes ☐ No				

Medicare Information	**Card Number:**										
	Individual Reference Number:		**Expiry:**	/							
Pension Card / Health Care Card (Please circle)	**Card Number:**										
	Expiry:	/ /									

Key Contact Person: (In case of emergency)			
Full Name:			
Relationship:		**Contact Number:**	
Residential Address:	**Street Address:** **Suburb:** **Postcode:**		

If you have a regular GP please tell us who:	
Doctor:	**Surgery:**
Do you have any health conditions or allergies we need to know about?	
☐ Yes ☐ No	**Please describe:**
Do you take any prescribed medication on a permanent or semi-permanent basis?	
☐ Yes ☐ No	**Name and dosage (if known):**

Young Person Signature: ___________________________________ **Date:** ___________________

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