Referral to headspace Taree

Fax to: 02 6539 3449
Email: headspacetaree@samaritans.org.au

Please Note: This referral is not accepted until an Intake Worker has made contact with the referrer via phone, fax or email. If contact is not made by a worker within 3 working days please call us on **02 6539 3440.**

headspace Taree is not a crisis service. If there are immediate mental health concerns for the young person please call the Mental Health Line on 1800 011 511, dial 000 or go to the closest hospital Emergency Department**.**

Staff ONLY - Type of Referral: ☐ In person ☐ Fax ☐ Email ☐ Phone		
Referral received on**:** _____/_____/_____	At time: _____	By: _____ (admin initial)
Confirmation fax sent _____/_____/_____	At time: _____	By: _____ (admin initial)

Section A. Details of Young Person

Has the young person agreed to this referral? ☐ Yes ☐ No (please note: referrals will not be accepted without the consent of the young person)	
If the young person is under 16 years, are the parents/carers aware of referral? ☐ Yes ☐ No	
Surname:	First name:
Gender: ☐ Male ☐ Female ☐ Other _____	Date of Birth: _____/_____/_____ Age: _____
Address:	
Suburb:	Postcode:
Phone (home):	Phone (mobile):
Email:	
Which contact/s would the young person prefer us to use? ☐ Home ☐ Mobile ☐ Email	

Emergency Contact:	
Name	Relationship to young person:
Address:	Suburb:
Postcode:	Phone: Mob:
Current legal/court issues current ☐ Yes ☐ No	Any AVO's for this YP ☐ Yes ☐ No

Reason for Referral

☐ Mental Health ☐ Physical Health ☐ Drug and Alcohol ☐ Vocational

Main issue/s:

Section B. Details of Referrer

☐ Self ☐ Family ☐ Friend ☐ Organisation

Name of Referrer:	Organisation:
Address:	Fax:
Phone: Mob:	Email:

Does the young person see any other services at the moment? ☐ Yes ☐ No

☐ Drug & Alcohol ☐ School Counsellor ☐ Other Counsellor ☐ Juvenile Justice

☐ Community Services ☐ Adult Mental Health ☐ CAMHS (Child and Adolescent Mental Health)

Other (please specify): _____

Does the young person have a regular GP? ☐ Yes ☐ No	Name of GP: Contact number of GP:

Practice name:

Practice address:

Does the young person have a mental health care plan? ☐ Yes ☐ No (if yes please attach if possible)

Other Information (IF KNOWN)

Aboriginal or Torres Strait Islander? ☐ No ☐ Aboriginal ☐ Torres Strait Islander(TSI) ☐ Both

Medicare # (if known):	Reference #:	Exp date:

Healthcare Card # (if known) Exp date:

Private Health Insurance: ☐ **Yes** ☐ **No** Fund: _____