# Referral Form

Please send the completed referral form via email or fax.
Email: headspacebundaberg@youturn.org.au
Fax: 4152 6602

**Eligibility Criteria**

- Young people between 12 and 25
- Young people not in acute crisis, nor currently suicidal.

Please note: We are not an emergency service. If the young person needs immediate assistance, please call 000 or report to the nearest hospital emergency department.

*Required field

Young Person's Legal Name*: _____

Young Person's Preferred Name: _____

Date of Birth*: _____ Aboriginal and/or Torres Strait Islander: ☐ Yes ☐ No

Gender: ☐ Female ☐ Male ☐ Non-Binary ☐ Other

Client's Address: _____

Suburb: _____ State: _____ Postcode: _____

Contact Number*: _____ Is this number the young person's? ☐ Yes ☐ No

**If No** - Contact's Name: _____ Relationship to young person: _____

Medicare Number: _____ Position on Card: ____ Expiry: _____

Health Care Card: ☐ Yes ☐ No - Number: _____ Expiry: _____

**Referral Reasons**

☐ General Practitioner Support
☐ Mental Health Support
☐ Alcohol and Other Drug Support
☐ Vocation or Educational Support
☐ Other: _____

**Please provide any relevant details about this referral**

**Name of Referrer:** _____
**Organisation:** _____
**Contact Number:** _____

**66 Woongarra St**
**PO Box 925**
**Bundaberg, QLD, 4670**

**T: 07 4152 3931**
**F: 07 4152 6602**
**headspace.org.au/bundaberg**

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