headspace Joondalup
Referral Form

Please sign and submit the completed form to info@headspacejoondalup.com.au or fax to 9301 0859
Referrals will not be accepted without the signed consent of the young person (see overleaf)

Name of young person		**Date of Referral** ___ / ___ / _____
Gender ☐ Male ☐ Female ☐ _____		**D.O.B.** ___ / ___ / _____
Is the young person of Aboriginal and or Torres Strait Islander descent? (tick as appropriate) ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander		
Address	Street name: _____ Suburb: _____ Postcode: _____	
Contact details	Mobile: _____ Home Phone: _____ Email: _____	
Preferred contact	☐ Mobile ☐ Home Phone ☐ Email ☐ Post	
Next of Kin/Emergency contact name		**Relationship** **Phone**
GP name		**Practice Name**
GP contact details	Phone: _____	Email: _____
Can we contact the GP? ☐ Yes ☐ No ☐ Unsure		

Referrer name (if different to the GP)		**Referring Agency**
Position		**Email** **Phone**
Reason for referral (including mental health or drug and alcohol history / previous treatment, physical health, vocational/ educational)		
Risk taking behaviours (self-harm, suicide ideation, substance use, aggression, self-neglect)		
Involvement with other agencies / services (if yes, please provide details)		
Relevant medical details (please attach an existing GP Mental Health Treatment Plan if applicable)		

BINDING MARGIN – NO WRITING

t: 08 9301 8900 **f:** 08 9301 0859 **e**: info@headspacejoondalup.com.au
Service location: Black Swan Health (lead agency for headspace Joondalup)
Sanori House, 126 Grand Boulevard, Joondalup, WA 6027

headspace National Youth Mental Health Foundation is funded by the Australian Government Department of Health

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CONSENT TO REFERRAL

This referral has been discussed with the young person who has agreed to the referral to headspace and sharing of information related to referral

Young Person
Signature: _____ Date: ___ / ___ / _____
Print Name: _____
Young Person's parent or caregiver (required if the young person is under 16 years of age)
Signature: _____ Date: ___ / ___ / _____
Print Name: _____ **Relationship**: _____
Referrer
Signature: _____ Date: ___ / ___ / _____
Print Name: _____

Office use only

Confirmation sent by (name) _____ on (date) ___ / _____ / _____

BINDING MARGIN – NO WRITING