



Fax to: 4931 1060

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 **4931 1000**.

headspace Maitland is not a crisis service. If there are immediate mental health concerns for the young person, please dial 000, go to the closest hospital Emergency Department or call Lifeline on 13 1114.

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: _____

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: _____