headspace Port Adelaide
Referral Form

Fax to (08) 8312 3025 or email to
headspaceportadelaide@centacare.org.au

Date:

Young Person's Details (Young person knows about & agrees to referral: ☐ Yes)

Name: _____ Address: _____

DOB: _____ Phone: _____

Gender: _____ Email: _____

Preferred mode of contact: ☐ SMS ☐ Phone call ☐ Email ☐ Letter

Does the young person have a Mental Health Care Plan: ☐ Yes ☐ No

Young Person's Language & Culture

Tick any that apply: ☐ Aboriginal ☐ Torres Strait Islander ☐ Culturally and Linguistically Diverse ☐ None

Does the young person require an interpreter? ☐ No ☐ Yes, [language – including Auslan]: _____

Reason(s) for Referral (tick all that apply)

☐ Mental health support

☐ Physical health support

☐ Financial counselling

☐ Alcohol and other drugs support

☐ Work & study support

☐ GP

Family and Friends Contact

Name: _____ Phone: _____

Relationship to young person: _____

Are they aware the young person is accessing the service: ☐ Yes ☐ No

Only contact in an emergency: ☐

Referrer Detail

Name: _____ Role: _____

Agency: _____ Phone: _____

Email: _____Fax: _____

Please note that **headspace** Port Adelaide is not a crisis service. Crisis care can be accessed via Western CAMHS (<16) on (08) 8161 7000 or Mental Health Triage (>16) on 13 14 65.

Consent

I, _____ [carer's name if young person under 16, young person's name if 16 or over], give consent for this referral to be made and give permission for _____ [referrer name] to exchange information with **headspace** Port Adelaide for the purpose of this referral.

Young person/carer signature: _____ Date: _____