headspace
Townsville
Location Riverway, Pioneer Park,
Village Boulevard, Thuringowa Central QLD 4817
Mail PO Box 4661, Kirwan QLD 4817
Tel 07 4799 1799 Fax 07 4799 1798
headspace.org.au

GP referral form

Date of referral: / /

Given Name: _____

Surname: _____

Address:_____

_____

Post Code_____

Phone: _____

Sex: Male ❒ Female ❒

DOB: / /

Indigenous Status

Aboriginal/Torres Strait Islander:

Yes ❒ No ❒

Current Living Environment:

Live Alone ❒

Home with Parents ❒

Home with Care Giver ❒

Other (eg Crisis Accommodation) ❒

Contact person/carer details

Name: _____

Telephone: _____

Does the young person have a health care card? Yes ❒ No ❒

Has the client or person responsible consented to this referral?

Yes ❒ No ❒

Please fax the completed form to:

4799 1798.

Also include if applicable: Mental Health Treatment Plan/ K10/ EPDS

Does this patient have an existing Mental Health Treatment Plan?

(Item 2700, 2701, 2715 or 2717)

Yes ❒ No ❒

Reason for referral:

Counselling Services ❒

Drug and Alcohol Intervention ❒

Social Recovery Groups ❒

Health Review/GP services ❒

Are there any known risks to self/others/staff?

Yes ❒ No ❒ If yes we will contact you for more information.

Referral notes:

_____

_____

_____

_____

_____

GP details:

Name: _____

Signature:_____

Practice: _____

_____

Phone: _____

Provider No: _____

headspace is funded by the Australian Government under the Promoting Better Mental Health – Youth Mental Health Initiative