Kimberley Aboriginal Medical Services Council Inc.

An Organisation of Aboriginal people, for Aboriginal people; controlled by Aboriginal people.

Sorting things out isn't always easy...
We are a youth-friendly space where young people can get on track and get the help they need.

REGISTRATION/REFERRAL FORM

Date: ……

If under 16 years are your parents/carers aware that you are coming to headspace?
Yes ☐ No ☐

Name:…….....

DOB: ..... I Identify my gender as: .....

Residential Address: ..... Suburb:……..Postcode:……..

Postal Address: ……..... Postcode: .....

Home Ph: …… Work Ph: …….....Mobile Ph: …….

Email: …….....

Which contact is preferable for us to use?
☐Home ☐Mobile ☐Email ☐Work

Do you prefer a male or female worker? .....

Emergency Contact: ..... Number: .....

Medicare Number: ..... Ref: .....Exp: .....

Allergies: ……..

Cultural Background:
☐ Aboriginal ☐ Torres Strait Islander ☐ Other: .....

Country of Birth:
☐ Australia ☐ Other: .....

Language Spoken at Home:
☐English ☐Aboriginal English ☐ Other: .....

Kimberley Aboriginal Medical Services Council Inc.

An Organisation of Aboriginal people, for Aboriginal people; controlled by Aboriginal people.

Sorting things out isn't always easy...
We are a youth-friendly space where young people can get on track and get the help they need.

Relationship status:
□Single □ In a relationship □ Its Complicated

Who do you live with?.....
□ Is overcrowding a concern for you?

Where do you live?

□ Private Housing	□AOD Treatment	□Boarding House
□Supported Accommodation	□ Refuge/Shelter	□ Public Places
□ Homeswest Housing	□ Couch Surfing	

Studies:
Are you currently a student? □ No □ Yes School**: .....**
□Primary □ High School □ TAFE □ University
□ Full-time □Part-time

□ No Education
Education completed:
□Primary
□ Year 8 or below □ Year 9 □ Year 10 □ Year 11 □ Year 12
□ Graduate □ Diploma/Cert□ Post Degree □ Other:…….

Employment:
□ Full-time □ Seeking □ Unemployed
□ Part-time □ Training (Full-time) □ Home duties
□ Other: .....
□ Casual/Seasonal □ Training (Part-time) □ Other: .....

Benefits:
□ Unemployment □ Disability Support Payments □ Sickness Benefit
□ Repatriation □ Youth allowance

Are there any other agencies helping you? □ No □ Yes

Please list**: .....**

Reason for referral: ……..

……

……

Kimberley Aboriginal Medical Services Council Inc.

An Organisation of Aboriginal people, for Aboriginal people; controlled by Aboriginal people.

Sorting things out isn't always easy...
We are a youth-friendly space where young people can get on track and get the help they need.

FOR AGENCIES MAKING A REFERRAL:

Name of Referrer: ..... Number: .....
Fax: .....

Referral Agency: ..... Is the young person aware of the referral? □ Yes □ No

Reason for Referral
Please provide as much detail as possible including strengths/abilities & safety concerns that may be present.

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Please note - a member of the team will contact you within a week to discuss the referral and the best way to book an appointment.

PLEASE RETURN TO: **headspace** Broome in person or fax: 9193 6122

Office use only - date entered into data system: **By:**