headspace Group Referral Form

DATE: _____/_____/_____

ADVENTURE GROUP	☐	ANGER MANAGEMENT GROUP	☐
ANXIETY GROUP	☐	POSITIVE COPING PROGRAM	☐

Client Surname: **Client First name:**	**Client D.O.B: / /**
Home Phone:	**Mobile Phone:**
Name of Person Referring:	**Relationship to Client:**
Organisation:	**Contact details:**
Reason for referral:	
Family Issues & Parental Involvement:	
Illicit Drug History:	
Current Prescription Medication:	
Current Work/Education:	
Other Services Involved(Incl. Primary Care Manager):	
What expectations do you have of the Group:	
Other Comments:	

Conditions of Referral: (please circle appropriate response)

- Referee be available for individual support if requested post-group **Yes / No**
- Referee to do post-group follow-up **Yes / No**
- Consent to release this information to **headspace** Barwon Facilitators **Yes / No**

Signature (of Client) : Date: / /