

**REFERRAL TO TUTORING SERVICE**

*headspace offer a tutoring service to provide educational support to students aged 12 to 25. The tutoring service offered by headspace is by request and can bee booked in a week or two in advance. Week days and times can vary due to the tutor’s availability so please nominate a preferred day and time for staff to book in appropriate clinic.*

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| **FAMILY/CARER MUST GIVE THEIR CONSENT FOR REFERRAL IF YP IS UNDER 16** |

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| **Family/Carer Details:** | Service/s Required:  🞏 Support & Advocacy  🞏 Information  🞏 Education & Training  🞏 Other (please describe)  ……………………………………………………………………… |
| **Name:** ….……………………………………………………………………..…  **Address:** ….……………………………………………………….……………  …………………………………………………………………………….…….……  **Phone:** ………………………………………………………….……………….  **Relationship to recipient:**  ….……………………………………………………………………..…………….. |

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| **Referrer:** | **School contact details if advocacy required**: |
| **Date :** ..………………………………………………………………….…  **Name:** ..……………………………………………………………………  **Organisation:** ..……………………………………………………….  **Telephone:** ..……………………………………………………………  **Email:** ..……………………………………………………………………. | **School:**  …………………………………………………….………………………  **Contact:**  …………………………………………………….……………………  **Phone:**  …………………………………………………….………………………  **Email:**  …………………………………………………….……………………….. |
| **Tutor to contact Referrer:** 🞏 Yes 🞏 No | |