#### To be completed by <u>Services</u> wishing to refer a young person to headspace Queanbeyan. GP MHTP with referral letter form the GP will also be accepted.

#### **Referral Criteria and Guidance**

headspace Queanbeyan is a free, youth-friendly and confidential service available to young people aged 12-25 years, in the Queanbeyan and surrounding area. The services available at headspace Queanbeyan include:

Counselling

- Vocational support
- Alcohol & Drug SupportGroup Support
- Psychologist services (under a GP Mental Health Treatment Plan)

eadspace

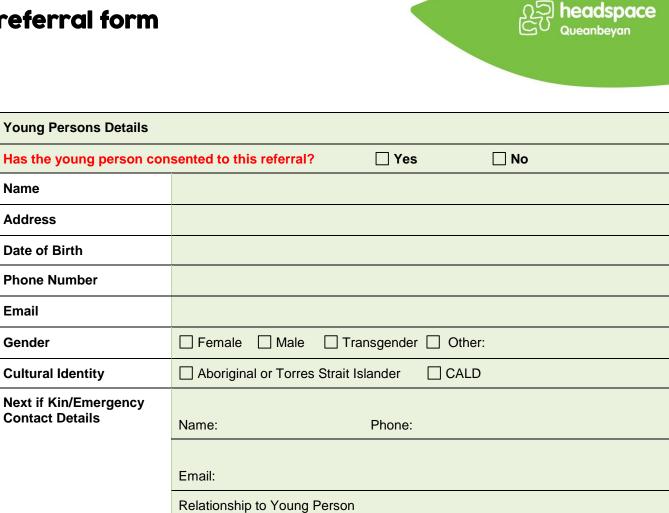
headspace Queanbeyan work with young people experiencing mild to moderate mental health issues such as stress, anxiety, depression or grief.

headspace Queanbeyan is not an acute mental health / crisis service. If you have any immediate concerns regarding the safety of a young person, please call:

•	NSW Mental Health Line	1800 011 511
•	ACT Crisis Assessment & Treatment Team (CATT)	1800 629 354
•	Kids Helpline	1800 551 800
•	Life Line	13 11 14
•	Emergency services	000

HealthLink Address: hsqbeyan

Address: 2/98 Monaro St Queanbeyan NSW 2620



Young Persons Supports				
Does the young person have an existing GP? If yes, please detail:	☐ Yes	No	Unsure	
Does the young person have an existing Mental Health Treatment Plan? Date on Plan: Issuing Dr:	☐ Yes	🗌 No	Unsure	
Does the young person require an interpreter? If so in which Language:	Yes	🗌 No	Unsure	
Does the young person currently receive support from any other services? If yes, please detail;	☐ Yes	No	Unsure	



#### **Reason for Referral:**

Please include any information which may be useful to assist with the referral (e.g. mental health, drug and alcohol, vocational / educational or physical health including past / current risk assessments). Please be as specific as possible as to what you would like for headspace. Please feel free to add any assessment to this referral.

What are some of the current issues? (please include info about duration, age of onset and pre-existing diagnoses):

What has been the impact of these? (eg relationships, school, work, home etc)

What are the young person's goals and objectives?

What other supporting documentation are you including (if applicable):



#### **Risk Factors:**

Please include any known risk factors. Suicide, non-suicidal self-injury, harm to others, vulnerabilities, homelessness, social withdrawal etc

Referring Service Details			
Date of Referral			
Name			
Position in Organisation			
Organisation			
Address			
Phone Number			
Email			
HealthLink Address			
Will you maintain support with the YP?	Yes No If yes, Support provided:		

The receipt of this referral form does not indicate acceptance to headspace Queanbeyan. Suitability of the referral will be determined following assessment with the young person. Please contact us on 5131 1500 should you wish to follow up on the progress of your referral.