

To be completed by Services 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
- Alcohol & Drug Support
- Group Support
- Vocational support
- Psychologist services (under a GP Mental Health Treatment Plan)

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 Details	
Has the young person consented to this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name	
Address	
Date of Birth	
Phone Number	
Email	
Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Other:
Cultural Identity	<input type="checkbox"/> Aboriginal or Torres Strait Islander <input type="checkbox"/> CALD
Next if Kin/Emergency Contact Details	Name: _____ Phone: _____
	Email: _____
	Relationship to Young Person _____

Young Persons Supports			
Does the young person have an existing GP? If yes, please detail: _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Does the young person have an existing Mental Health Treatment Plan? Date on Plan: _____ Issuing Dr: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Does the young person require an interpreter? If so in which Language: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Does the young person currently receive support from any other services? If yes, please detail; _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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):

referral form

Risk Factors: <i>Please include any known risk factors. Suicide, non-suicidal self-injury, harm to others, vulnerabilities, homelessness, social withdrawal etc</i>

Referring Service Details	
Date of Referral	
Name	
Position in Organisation	
Organisation	
Address	
Phone Number	
Email	
HealthLink Address	
Will you maintain support with the YP?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.