referral form

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

Please return the completed referral form and any other attachments to us using a secure method. We use HealthLink and SOPHOS: Post is also welcome.

HealthLink Address: hsqbeyan

Address: 2/98 Monaro St Queanbeyan NSW 2620

Email: Via Encrypted ONLY email to hs.Queanbeyan@marathonhealth.com.au
You can use our SOPHOS encryption tool for free.

Follow this Link to begin the encryption process

referral form

Young Persons Details	
Has the young person consented to this referral?	☐ **Yes** ☐ **No**
Name	
Address	
Date of Birth	
Phone Number	
Email	
Gender	☐ Female ☐ Male ☐ Transgender ☐ Other:
Cultural Identity	☐ Aboriginal or Torres Strait Islander ☐ 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: _____ _____	☐ 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

referral form

headspace Queanbeyan

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. A letter of acknowledgment of this referral will be sent to you via HealthLink (GP's) or secure email SOPHOS. Follow up contact will be made once the young person has been assessed.