headspace Queanbeyan

Referral Form

To be completed by <u>services</u> wishing to refer a young person to headspace Queanbeyan

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 to:

Fax: 02 6103 0586 Email:hs.Queanbeyan@marathonhealth.com.au

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

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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		
Parent/Carer Details (if applicable)	Name:	Phone:	

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.

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?	☐ Yes	☐ No	☐ Unsure
Does the young person currently receive support from any other services? If yes, please detail; _____________________________ ____	☐ Yes	☐ No	☐ Unsure