**Referral Form**

***To be completed by services 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:

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| * Counselling | * Vocational support |
| * Alcohol & Drug Support * Group 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 * Life Line | 1800 551 800  13 11 14 |
| * Emergency services | 000 |

Please return the completed referral form to:

|  |  |
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| Fax: 02 6103 0586 | Email:[hs.Queanbeyan@marathonhealth.com.au](mailto:hs.Queanbeyan@marathonhealth.com.au) |
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| --- | --- |
| 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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| 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.* |
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|  |  |
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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: |

|  |  |  |  |
| --- | --- | --- | --- |
| 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 |