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:

- Youth Friendly GPs
- Alcohol & Drug Support
- Psychologist services (under a GP Mental Health Treatment Plan)
- Counselling
- Vocational support

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
- Emergency services 000

Please return the completed referral form to:

headspace Queanbeyan
98 Monaro Street (Corner Crawford Street)
Queanbeyan NSW 2620
Phone: 02 6298 0300
Fax: 02 6298 0399

Self-Referral

Young people can refer themselves to headspace Queanbeyan. Young people are encouraged to contact headspace Queanbeyan directly by either phoning, emailing or walk-in to the centre.

Family and Friend Referral

Family, carers and friends can refer a young person to headspace Queanbeyan. Please contact headspace Queanbeyan directly by either phoning, emailing or walk-in to the centre.
### Young Persons Details

<table>
<thead>
<tr>
<th>Has the young person consented to this referral?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Date of Birth</th>
<th>Phone Number</th>
<th>Gender</th>
<th>Cultural Identity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- □ Female  □ Male  □ Transgender  □ Other:  □ Aboriginal or Torres Strait Islander  □ CALD

### Referring Service Details

<table>
<thead>
<tr>
<th>Date of Referral</th>
<th>Name</th>
<th>Address</th>
<th>Organisation</th>
<th>Position in Organisation</th>
<th>Phone Number</th>
<th>Email</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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).*

### Does the young person have an existing GP?

- □ Yes  □ No  □ Unsure

If yes, please detail:

### Does the young person have an existing Mental Health Treatment Plan?

- □ Yes  □ No  □ Unsure

### Does the young person require an interpreter?

- □ Yes  □ No  □ Unsure