MATT and Joondalup
Tel: (08) 9301 8999
Fax: (08) 9301 1325
Email: hYEPPReferral@headspacejoondalup.com.au

headspace Youth Early Psychosis Program Assessment Referral

This is a referral for ***assessment only***. Therefore, clinical care and responsibility remains with the referrer until such time as contact is made to advise that a young person is eligible and has been accepted to the hYEPP service for ongoing care. The Mobile Assessment and Treatment Team will conduct a comprehensive biopsychosocial assessment with the young person, whilst considering the inclusion/exclusion criteria of the service, such as age, catchment areas, first episode psychosis/ultra-high risk state, and what the most appropriate long-term service for the young person will be.

Inclusion Criteria:

- Aged 12-25 years
- Diagnosis of psychosis or of ultra high risk of psychosis (characterized by attenuated psychotic symptoms, brief limited psychotic symptoms, or trait vulnerability, and deterioration in functioning/persistent low functioning).

Exclusion Criteria:

- Under the age of 12 years or over the age of 25 years at time of referral
- More than 12 months of treatment for psychosis by another mental health service
- Symptoms present only in the context of substance intoxication
- More likely to benefit from another service or program.

Inclusion of additional information (triage notes, discharge summaries, medication charts, etc.) will be helpful in the assessment process. **Note:** headspace is a non-government organisation that does not have access to Government records, this includes PSOLIS.

YOUNG PERSON DETAILS		
Name:		
Address:		
DOB:		Gender:
Contact numbers: Mobile:		Home: ( )
Indigenous / Cultural Identity:	Interpreter required: Yes ☐ No ☐ Language:	
IMPORTANT CONTACT DEATILS		
Next of Kin / Emergency Contact:		PH:
General Practitioner:		PH:
GP Practice:		PH:
REFERRER DETAILS		
Name:	Organisation / Position:	
Address:	Email: Phone: Fax:	

MATT and Joondalup
Tel: (08) 9301 8999
Fax: (08) 9301 1325
Email: hYEPPReferral@headspacejoondalup.com.au

REASON FOR REFERRAL

Presenting issues:

CURRENT MENTAL HEALTH SYMPTOMS

DURATION OF SYMPTOMS

When was this young person first recognised to have the identified presenting issues:

Details:

History of prodromal symptoms? Yes ☐ No ☐ Uncertain ☐

Estimated length of Duration of Untreated Psychosis (DUP)?

Evidence of negative symptoms? Yes ☐ No ☐ Uncertain

How have the mental health issues impacted on functioning?

Details:

Level of Insight (please select box)

☐ Excellent: understands diagnosis and need for treatment
☐ Moderate: accepts something is wrong and willing to accept treatment
☐ Poor: accepts something is wrong,, but is unwilling to accept treatment
☐ Insightless: does not perceive self as having an illness

MATT and Joondalup
Tel: (08) 9301 8999
Fax: (08) 9301 1325
Email: hYEPPReferral@headspacejoondalup.com.au

headspace Youth Early Psychosis Program

TREATMENT HISTORY – MENTAL HEALTH

Previous contact with other mental health services or private practitioners? Yes ☐ No ☐ Unknown ☐
Details:

Previous psychiatric diagnoses? Yes ☐ No ☐ Unknown ☐
Details:

Previous hospitalisations? Yes ☐ No ☐ Unknown ☐
Details:

Previous medications? Yes ☐ No ☐ Unknown ☐
Details:

Current medications? Yes ☐ No ☐ Unknown ☐
Details:

MEDICAL HISTORY

Are there any physical health issues / illnesses? Yes ☐ No ☐ Unknown ☐
Details:

Have recent investigations been completed (i.e, baseline bloods including metabolic, ECG, CT / MRI Head)?

Relevant findings / date completed:

FAMILY PSYCHIATRIC HISTORY (mental illness/addiction/suicide)

SOCIAL SITUATION (family relationships, level and nature of supports, accommodation, study / employment, finances)

SUBSTANCE USE (type and amount / frequency)

History: Yes ☐ No ☐ Current: Yes ☐ No ☐

Details:

MATT and Joondalup
Tel: (08) 9301 8999
Fax: (08) 9301 1325
Email: hYEPPReferral@headspacejoondalup.com.au

headspace Youth Early Psychosis Program

FORENSIC ISSUES

History of Criminal Charges: Yes ☐ No ☐
Details:

Current or Pending Charges / Issues: Yes ☐ No ☐
Details:

RISK ASSESSMENT

History of self-harm / suicidality? Yes ☐ No ☐
Yes ☐ No ☐

Current thoughts / plans / intent:

Details:

History of violence? Yes ☐ No ☐
Current thoughts / plans / intent: Yes ☐ No ☐

Details:

History of risk from others? Yes ☐ No ☐

Details:

MENTAL HEALTH ACT STATUS

Voluntary / Involuntary

Community Treatment Order: Yes ☐ No ☐ Expiry Date _____ / _____ / _____

OTHER SERVICES INVOVLED

Are there any other support services involved with the young person? Yes ☐ No ☐

Details:

INTERIM PLAN (What interim arrangements are in place for care of this young person pending outcome of referral?)

IS THE YOUNG PERSON AWARE OF THE REFERRAL? **Yes** ☐ **No** ☐

IS THE YOUNG PERSON AGREEABLE TO REFERRAL? **Yes** ☐ **No** ☐

Signature: _____ **Date Referral Received:** _____