headspace Early Psychosis
Referral Form

Program Details

The headspace Early Psychosis provides specialised assessment and intervention for young people aged 12-25 who are at risk of or experiencing a first episode of psychosis. Upon referral to the program, the young person will be assessed by our multi-disciplinary team. Feedback on the outcome of the assessment will be provided to the referrer.

Please return completed form to:

Email: headspacesouthport@headspacesouthport.org.au
Phone: 07 5509 5900 **Fax**: 07 5527 1251 **Mobile**: 0423 614 781

All enquires are welcome

Person Being Referred

First Name:		Last Name:			
Date of Birth:		Gender:		Pronouns:	
Primary Mobile Contact & Name:		Secondary Phone Contact & Name:			
Email:					
Address:					
Parent/ Guardian Name and Contact Number: (if consent given by young person):					

Authorisation Of Referral (By Person Being Referred)

Please NOTE: Referrals will not be processed without signed consent.

I am aware that this referral is being made. I understand that I can withdraw from this referral or from the referred service at any time.

I give permission for **headspace** Southport to use my contact details above for future contact with me.

Yes ☐ No ☐

I give permission for the **staff** of **headspace** Southport to obtain relevant information from government and non-government agencies, from doctors and other health professionals specifically relevant to my care whilst being a client of **headspace** Southport.

Signed			
Print Name:		Date:	

Referrer (Individual Completing This Document)

Contact Name:			
Email:			
Practice Name/Organisation:		Date:	
Phone:		Mobile:	
Profession:		Fax:	
Signed:			

headspace National Youth Mental Health Foundation is funded by the Australian Government Department of Health

Does the young person have a preferred language other than English: Yes ☐ No ☐
If yes, please specify:

Does the young person have any current mental health diagnoses: Yes ☐ No ☐
If yes, please specify:

Does the young person have any physical health condition/diagnoses: Yes ☐ No ☐
If yes, please specify:

General Patient Information

Noticeable decline or drop in functioning (moderate difficulty in social, occupational or school functioning - not functioning at any age appropriate level)	Yes ☐ No ☐
1st degree relative with psychosis, schizophrenia or BPAD (parents, brother or sister)	Yes ☐ No ☐
Attending school/university/TAFE	Yes ☐ No ☐
Employment	Yes ☐ No ☐
Substance misuse	Yes ☐ No ☐
Suicidal ideation	Yes ☐ No ☐
Suicidal plan	Yes ☐ No ☐
Suicidal intent	Yes ☐ No ☐
Deliberate Self Harm	Yes ☐ No ☐
Violence or aggression towards others	Yes ☐ No ☐

Symptomology

Hallucinations or perceptual disturbances: auditory/visual/tactile e.g. Hearing voices or sounds (banging, clapping, scratching), seeing people or shadows, feeling crawling sensation on skin	Yes ☐ No ☐
Delusional beliefs (ideas of reference, paranoia, suspiciousness, grandiosity)	Yes ☐ No ☐
Blunted affect	Yes ☐ No ☐
Odd or unusual behaviour	Yes ☐ No ☐
Decrease in motivation/energy/lack of interest in activities	Yes ☐ No ☐
Social withdrawal/isolation	Yes ☐ No ☐
Cognitive decline (concentration, memory, planning)	Yes ☐ No ☐
Change in appetite and/or change in sleep pattern/quality/quantity	Yes ☐ No ☐

Current Medications

Name	Dose

FOR ALL QLD HEALTH AND TERTIARY HOSPITAL SERVICE REFERALS:

A referral from QLD Mental Health Services or any other tertiary health service is considered as a possible transfer of care upon meeting the headspace Early Psychosis criteria. So, prior to acceptance of a referral of a young person, headspace Early Psychosis requires to have all the following information before offering an assessment with the program. This will give us a better opportunity to provide an appropriate and safe service. It would also reduce any risk associated with missing information.

- Completed headspace Early Psychosis referral and consent forms
- Last Consumer Assessment document/rapid triage form
- Latest case review notes and care plan
- A copy of all medical review notes (At least for the last three months)
- Any update on potential risks and changes in mental health presentation not captured in the previous documents
- A copy of all blood tests, imaging or any other investigation which have been done during assessment, admission or case management period (for the last 6 months)

Privacy Statement: All information provided is protected under our privacy and confidentiality guidelines.