**headspace** Armadale is a free, youth-friendly and confidential service available to young people aged 12 – 25 years, in the south east metropolitan region of Perth. **headspace** Armadale brings together a range of co-located community-based and government agencies, to provide a holistic service as a “one-stop-shop” for young people. We offer information, intake, assessment and referral.

The services available at **headspace** Armadale include:

|  |  |
| --- | --- |
| * Youth Friendly General Practitioner/s * Youth Support Workers * Sexual health clinic | * Drug and alcohol outreach worker * MBS Psychological services * Vocational support worker |

**How to refer**

**Professional Referral**

* Referrals accepted from GP’s, Allied Health Professionals, community-based agencies and educational institutions
* Where available, GP’s should include a copy of the client’s Mental Health Treatment Plan
* GP Mental Health Management options:

By your own GP

By headspace GP (While client is engaged at headspace)

By headspace GP (Ongoing) (Handover all Medical and Mental Health Management)

**Client Details**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of Referral** | | | **DOB**      /     /      **Age** | | |
| **Name** | | | **Gender** | | |
| **Address** | | | | | |
| **Email** | **Mobile** | | | **Home Phone** | |
| **Medicare No.** | | **Reference No.** | | | **Expiry Date:** |

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| --- |
| **Are there any safety concerns when contacting the patient by phone/mail?** |
| **Consent to contact young person via: (e.g. confirm appointments etc.)**  **Mobile:**   Yes  No **Text:**  Yes  No **Voicemail:**  Yes  No  **Email:**  Yes  No **Mail:**  Yes  No **At home:**  Yes  No  **Preferred method of contact *(this can change and other arrangements can be made):*** |

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| --- |
| **Language spoken at home?** |
| **Ability to speak English?**  Very well  Well  Not well  Not at all **Preferred Language** |
| **What is the client’s cultural background?** Aboriginal  TSI  Other  Unknown |
| **Who does the young person live with?** |
| **Education/employment status?** |
| **Is the client aware and consented to the referral and wanting treatment?** |

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| --- | --- | --- | --- |
| **Next of Kin (MUST be completed if client is under 16 unless mature minor process followed)** | | | |
| **Next of Kin name** |  | **Mobile number** |  |
| **Relationship to client** |  | **Home number** |  |
| **Is the young person’s parent/guardian aware that this referral has been made?**  Yes  No | | | |
|  |  |  |  |

**Reason for Referral**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Presenting Issues** *(please include here any information which may be useful as background information to assist with the referral e.g. mental health, drug and alcohol, vocational/educational, physical health, including past/current risk assessments)* | | | | | | | | |
| Mental health  Situational  Eating | | Physical health  Vocational/education  Home/environment | | | Sexual health  Social support  Friendships | Alcohol/drugs  Family support  Relationships/sexuality | | |
| Mental health diagnosis (if relevant) | |  | (*Please attach copy of current Mental Health Treatment Plan if available)* | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| Duration of presenting problem | |  | | | | | | |
| **Recent Stressors** *Are there any legal proceedings pending? (please note headspace is unable to provide opinion re: legal matters or supporting documents)* | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| **Client History** *(Relevant biological, psychological, physical and social history, including family history)* | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| **Relevant medications:** |  | | | | | | | |
| **Risk to self or others** *(include self-harm/suicide attempts, violence, threats of violence)*  **PLEASE NOTE: headspace does not provide crisis or acute care, if in crisis please refer to the closest Emergency Department or call the Mental Health Emergency Response Line (MHERL) on 1300 555 788** | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| **Other Care Providers Involved (Previous/Current)** *(is the young person linked in with any other services? For example CAMHS)* | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| **Admissions to hospital related to mental health?** | | | |  | | | **If so, how many?** |  |

**Referrer Details**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** |  | | | **Relationship to the client** | |  | |
| **Address** | |  | | | | | |
| **Organisation** | | |  | | **Contact Number** | |  |

**Client’s GP (if not the referrer):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** |  | | **Practice** |  |
| **Address** | |  | | |

**Consent Details**

Please indicate who is consenting to collection, use and disclosure of personal health information:

|  |  |  |  |
| --- | --- | --- | --- |
| 🞎 Adult client | 🞎 Adolescent client (aged 16 or over) | 🞎 Parent/guardian | 🞎 Mature minor |

All information will be treated confidentially and will not be used for any other purposes that what is stated in the full consent form (signed during the first appointment). I am aware that this referral is being made. I understand I can withdraw from this service at any time. The client has been made aware of this referral.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |
|  | Client name |  |  | Client signature |  |  | Date |  |
|  |  |  |  |  |  |  |  |  |
|  | Parent/guardian name |  |  | Parent/guardian signature |  |  | Date |  |

**FAX THIS REFERRAL TO HEADSPACE ARMADALE ON 9393 0399 or email to** [**referrals@headspacearmadale.com.au**](mailto:reception@headspacearmadale.com.au)

Please note that headspace Armadale does not provide crisis or acute care mental health services.

For mental health emergencies contact the Mental Health Emergency Response Line on 1300 555 788.

Please use this MHCP or attach your own

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **GP MENTAL HEALTH TREATMENT PLAN (MBS ITEM NUMBER 2715/2717 or 2700/2701)** | | | | | |
| **Patient’s Name** |  | **Date of Birth** | | |  |
| **Address** |  | **Phone** | | |  |
| **GP Name/Practice**  **Provider Number** |  | | | | |
|  |  | | | | |
| **PRESENTING ISSUE(S)**  What are the patient’s current mental health issues |  | | | | |
| **PATIENT HISTORY**  Relevant biological, psychological, physical  social history including family history of mental disorders and any relevant substance abuse |  | | | | |
| **MEDICATIONS**  (attach information if required) | **Is the patient receiving psychotropic medication?  Yes  No If yes, *please specify* *below***  Benzodiazepines & Anxiolytics  Antidepressants  Phenothiazines & Tranquilisers  Mood Stabilisers | | | | |
| **PREVIOUS MENTAL HEALTH CARE** | **Has the patient ever received specialist mental health care before (public/private, medical/allied health)?** NoYes **If yes, *please specify* *below*** | | | | |
| **OTHER RELEVANT INFORMATION** | *Are there any legal proceedings pending? (please note InFocus is unable to provide opinion re: legal matters or supporting documents)* NoYes **If yes, *please specify***  *For perinatal referrals only:*  Due birth date:       Actual birth date: | | | | |
| **RESULTS OF MENTAL STATE EXAMINATION**  Record after patient has been examined | **Appearance and Behaviour**  Normal  Other | | **Mood** (Depressed/Labile)  Normal  Other | | |
| **Thinking** (Content/Rate/Disturbance)  Normal  Other | | **Affect** (Flat/Blunted)  Normal  Other | | |
| **Perception** (Hallucinations etc.)  Normal  Other | | **Sleep** (Initial Insomnia/Early Morning Wakening)  Normal  Other | | |
| **Cognition** (Level of Consciousness/Delirium)  Normal  Other | | **Appetite** (Disturbed Eating Patterns)  Normal  Other | | |
| **Attention/Concentration**  Normal  Other | | **Motivation/Energy**  Normal  Other | | |
| **Memory** (Short and Long Term)  Normal  Other | | **Judgement** (Ability to make rational decisions)  Normal  Other | | |
| **Insight**  Normal  Other | | **Anxiety Symptoms** (Physical and Emotional)  Normal  Other | | |
| **Orientation** (Time/Place/Person)  Normal  Other | | **Speech** (Volume/Rate/Content)  Normal  Other | | |
| **RISKS AND CO-MORBIDITIES** | Suicidal Ideation  **Yes  No**  Current Plan  **Yes  No** | | | Suicidal Intent  **Yes  No**  Risk to Others  **Yes  No** | |
| **OUTCOME TOOL USED**  E.g. K10, DASS-21 | **RESULTS** *(please attach with referral)* | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **GP MENTAL HEALTH TREATMENT PLAN (MBS ITEM NUMBER 2715/2717 or 2700/2701)** | | | | | |
| **DIAGNOSIS** | **ICD-10 Primary care diagnostic categories**  P Health Professional / Scluding dfamily historyF1 – Alcohol & Drug Use  F2 – Psychotic disorders  F3 – Depression  F4 – Anxiety  F5 – Unexplained somatic complaints  Unknown  Other | | | | |
| **PATIENT NEEDS/MAIN ISSUES** | | | | **GOALS** Record the mental health goals agreed to by the patient and GP and any actions the patient will need to take | |
|  | | | |  | |
| **TREATMENTS**  Treatments, actions and support services to achieve patient goals | | | | **REFERRALS** | |
| Referred for which strategies:  Diagnostic Assessment  Psycho-education  Interpersonal therapy  Narrative Therapy  Family Therapy (perinatal referrals only)  Other *(please specify)* | | Cognitive-behavioural therapy (CBT):  Behavioural Interventions  Cognitive Interventions  Relaxation Strategies  Skills training  Other CBT interventions | |  | |
| **CRISIS/RELAPSE**  If required, note the arrangements for crisis intervention and/or relapse prevention | | |  | | |
| **COMPLETING THE PLAN**  On completion of the plan, the GP is to record that s/he has discussed with the patient:  The assessment;  All aspects of the plan, including referrals to other providers  Agreed date for review  Offered a copy of the plan to the patient and/or their carer (if agreed by patient) | | | | | **DATE MENTAL HEALTH TREATMENT PLAN COMPLETED** |
| **REVIEW DATE** (initial review 4 weeks to 6 months after completion of plan) |