Youth Plus Referral Form

Once completed please email to: hs.Lithgow@marathonhealth.com.au

Do you believe this young person is at risk of harm to themselves or other people? ☐ Yes ☐ No

Youth+ Clinic is an early intervention and prevention service. If the young person is at risk of harm to themselves or to someone else, they are no suitable for headspace services. Please contact the mental health hotline on 1800 011 511 (24 hours) for appropriate services, take them to your nearest hospital, or call 000.

The Youth+ Clinic is a brief intervention service that offers young people 12-25 years old, in crisis, a **set of specific individual appointments**. During these sessions, a clinician will talk with the young person and provide support, help navigate their way through the crisis, and link them into further services as needed.

Criteria for the Youth+ service

- Has not had more than 6 months of previous psychological treatment for the presenting issue
- Willing to engage in weekly sessions
- Thoughts and feelings of suicide and self-harm
- Impulsive and/or self-destructive behavior
- Changing in emotions and strong, overwhelming feelings
- Is aged between 12 and 25
- Does not meet criteria for NSW Community Health or Child and Adolescent/Youth Mental Health Service

Exclusion criteria……

- Evidence of psychosis, disordered eating, primary alcohol/drug dependence disorder, suicidal ideation with plan or intent, significant current self-harm or risky behavior.
- Complex issues requiring case management

Client information….

Young persons preferred name:			
Young persons last name:			
Are they known by any other names:			
date of birth:		age:	
gender:		pronouns:	
Phone number:	Email (optional):		
Indigenous/Cultural Identity: ☐ Aboriginal	☐ Torres Strait Islander	☐ Both	☐ Non-Indigenous
Residential address:	Street: Suburb:	Postcode:	
Who with?	☐ At home with family ☐ Staying with friends	☐ Living alone ☐ supported accommodation	☐ Homeless ☐ Refuge

Next of Kin….

Full name:	
Relationship to young person:	
Contact number:	
Do we have permission to speak with this person:	☐ yes ☐ no

If the young person is under 16 does the parent/guardian consent to this referral?	☐ yes ☐ no
Name of parent/guardian:	
Parent/guardian contact number:	

Referral information….

Presenting Issues/Reason for referral: Please attach any relevant assessment notes, discharge summaries, and/or additional information.
Please list details of primary mental/physical health diagnoses and any other conditions that impact on the young person's wellbeing:
Current Medications/Treatments (please provide details):
Additional information: Please outline any additional information, history, or anything else you or the young person would like to add

Safety considerations (please note these are not exclusion criteria)….

Suicide? ☐ yes ☐ no Details:
Non-accidental self-injury? ☐ yes ☐ no Details:
Substance use? ☐ yes ☐ no Details:
Past physical or verbal aggression? ☐ yes ☐ no Details:
At risk of homelessness? ☐ yes ☐ no Details:
Risk talking and/or impulsive behaviour? ☐ yes ☐ no Details:

Current and historic support details….

Care Provider type	Name	Contact details	Consent to Liaise?
General Practitioner			
School Counsellor			
Private Psychologist			
Homelessness Provider			

Psychiatrist			
Child protection Agency			
D&A services			
NDIS Involvement			
Other			

Referrers details….

Name:	
Position / Organization:	
Email:	
Best contact number:	
Address:	

best person to contact about this referral: ☐ Young person ☐ Parent/Guardian ☐ Referrer

Consent….

Please note that for headspace Lithgow to accept this referral:

- The young person is aged between 12 and 25 years of age
- The young person consents to this referral
- We require consent of the young person or parent/guardian if under the age of 16.

If this is not possible, please get in touch and we'll talk you through some other options.

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

_____	_____	_____
Client name	**Client signature**	**Date**
_____	_____	_____
Parent/Guardian name	**Parent/Guardian signature**	**Date**
_____	_____	_____
Referrer name	**Referrer signature**	**Date**

Please note that receipt of the referral does not indicate acceptance to the Youth+ Clinic. The suitability of the referral will be determined following review by our team. If you have any queries about your referral, please contact us on 6352 7600 or at hs.Lithgow@marathonhealth.com.au and we can discuss further.

**Please complete this form with as much information as possible and provide any supporting clinical documentation available as this will assist our team in determining suitability and the assessment process. If the referral does not have adequate information, please be aware that we may need to contact you for further information in order to proceed with the referral.