headspace Early Psychosis Referral Form

MATT Joondalup
T: (08) 9301 8999
F: (08) 9301 0859

E: earlypsychosisReferral@headspacejoondalup.com.au

headspace Early Psychosis is a comprehensive, early intervention mental health service for young people experiencing psychosis or who are at Ultra-High Risk (UHR) of psychosis.

FOR TERTIARY SERVICES

You may send your own assessments, as well as risk assessments, in lieu of this form. Please note as we are a non-government organisation, we do not have access to government records, including PSOLIS. Please call if you have any queries.

FOR ALL OTHER REFERRERS

Use of this referral form is recommended but not essential. Referrals can be made by letter, email, or phone. It is okay if you can't fill out the whole form, just give as much information as you can. We may call you for additional details if needed. If you're not sure of anything, give us a call.

Young People and Families can also walk in or call through to a headspace Early Psychosis center for support.

headspace Early Psychosis does not provide acute or urgent responses to clients before they have been discussed at our intake meeting and accepted for assessment. If the matter is urgent, please contact CAMHS Crisis Connect on 1800 048 636 (if under 18 years of age) or the Mental Health Emergency Response Line on 1300 555 788 (over 18 years of age). Alternatively, please present to the nearest Emergency Department.

INCLUSION CRITERIA

- Aged 12-25 (inclusive) at time of referral
- Diagnosis of psychosis or Ultra-High Risk of psychosis
- Within catchment areas (parts of North and East Metropolitan Perth)

EXCLUSION CRITERIA

- More than 24 months of medical treatment for psychosis by another service/practitioner
- Symptoms are only present when acutely intoxicated
- More likely to benefit from another service or program

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YOUNG PERSONS DETAILS		
Name:		
Address:		
DOB:	Gender:	Preferred Pronouns: Select or Freetype
Mobile:	Home:	Cultural Identity:
Email:		Language:
		Interpreter Required: ☐ Yes ☐ No

Indigenous / Cultural Identity: Does the YP identify as:

☐ Yes ☐ No Aboriginal
☐ Yes ☐ No Torres Strait Islander
☐ Both Aboriginal and Torres Strait Islander
☐ Neither
☐ Prefer not to answer

MEDICARE DETAILS	
Card Number:	
IRN/Position on Card:	Expiry Date:

IMPORTANT CONTACTS	
Next of Kin / Emergency Contact:	Ph:
Relationship:	
General Practitioner:	Ph:
GP Practice:	

REFERRER DETAILS	
Name:	
Organisation:	Position:
Address:	
Phone:	Email:

REASON FOR REFERRAL *(e.g., when did issues begin, impact on school/work, duration and frequency of symptoms)*

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LEVEL OF INSIGHT

- ☐ 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
- ☐ None: does not perceive self as having an illness

MENTAL HEALTH HISTORY

Previous contact with mental health services/private practitioners? Details:	☐ Yes ☐ No
Previous psychiatric diagnoses? Details:	☐ Yes ☐ No
Previous hospitalisations? Details:	☐ Yes ☐ No
Previous medications? Details:	☐ Yes ☐ No
Current medications? Details:	☐ Yes ☐ No

MEDICAL HISTORY

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

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Have any recent investigations been completed (i.e, blood tests, ECG, CT/ MRI)? Details:	☐ Yes ☐ No ☐ Unknown If Yes, date completed:
FAMILY PSYCHIATRIC HISTORY	
Is there any family history of mental illness? ☐ Yes ☐ No ☐ Unknown	If Yes, Details:
SOCIAL SITUATION *(family relationships, level of support, accommodation, study, employment, finances)*	
SUBSTANCE USE	
History of use? ☐ Yes ☐ No ☐ Unknown	Current use? ☐ Yes ☐ No ☐ Unknown
Details:	
FORENSIC HISTORY	
History of criminal charges? If Yes, Details:	☐ Yes ☐ No ☐ Unknown
Current or pending charges? If Yes, Details:	☐ Yes ☐ No ☐ Unknown
RISK ASSESSMENT	
History of self-harm / suicidality? If Yes, Details:	☐ Yes ☐ No
Current thoughts / plans / intent? If Yes, Details:	☐ Yes ☐ No
History of violence?	☐ Yes ☐ No
Current thoughts / plans / intent? If Yes, Details:	☐ Yes ☐ No

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History of risk from others? If Yes, Details:	☐ Yes ☐ No
Current thoughts / plans / intent? If Yes, Details:	☐ Yes ☐ No
MENTAL HEALTH ACT STATUS	
If in hospital ☐ Voluntary ☐ Involuntary	
Community Treatment Order? ☐ Yes ☐ No	Expiry Date:
OTHER SERVICES INVOLVED	
Are there any other services involved with the young person? Details:	☐ Yes ☐ No
INTERIM PLAN	
CONSENT	
hEP is a voluntary service, unless the young person is under the Mental Health Act or has a Community Treatment Order in place. ***Please ensure the young person is aware of and consenting to the referral.***	

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

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

Signature: **Date:**