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| **YOUTH EARLY SUPPORT SERVICE**  **REFERRAL FORM FOR GPs** |

*Please note that the Youth Early Support Service (YESS) provides treatment to young people aged 12 to 25 who require more support than headspace Primary Care is funded to provide, but who do not meet the Child Youth Mental Health Service (CYMHS) criteria. Please check the boxes below as a starting point to determine suitability for referral to YESS:*

Has not had more than 6 months’ previous psychological treatment for current presentation

Will require more than 10 treatment sessions, or has moderately complex issues requiring case management

Does not require more than 12 months’ treatment

Does not meet CYMHS criteria

Does not experience psychosis

**Important information about your referral:**

**Has the person consented to this referral?**  Yes  No

**If under 16 years, is a parent/guardian aware of the referral?**  Yes  No

If you have answered ‘no’ to the above question, your referral may not be accepted. Please contact us and we’ll talk you through some other options.

Please note that receipt of the referral does not indicate acceptance. The suitability of the referral will be determined following review by our clinicians. If you have any queries about your referral, please contact the office at **02 4720 8811** and we can discuss further.

If the client needs urgent assistance, please call the Mental Health Line on **1800 011 511**, dial **000**, or take the young person to the nearest hospital emergency department.

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| **Section 1: YOUNG PERSON’S DETAILS** | | | | |
| First name |  | Last name | |  |
| Gender |  | Preferred pronoun(s) | |  |
| D.O.B. |  | Phone number | |  |
| Email address |  | | | |
| Address |  | | | |
| Suburb |  | Postcode |  | |
| School |  | | | |
| Year |  | School Counsellor | |  |
| Has seen school counsellor  Previously  Currently | | | | |

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| **Section 2: NEXT OF KIN** | |
| Full name: |  |
| Relationship to young person: |  |
| Phone number: |  |

Do we have permission to speak to this person?  Yes  No

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| **Section 3: HEALTH INFORMATION** |

**Presenting issues/reason for referral:**

Please attach any relevant assessment notes, discharge summaries, and/or additional information

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Please list details of any medications the person is currently prescribed and how long these medications have been prescribed for:

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Please outline any additional information, history, or anything else you or the applicant would like to add:

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| **Section 4: CURRENT AND HISTORIC SUPPORT DETAILS** |

Is the young person currently, or have they previously been, engaged with any other services including psychologist, psychiatrist, child protection agency, homelessness agency, etc

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| **Section 5: 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…………………………………………………………………………………………………………………………………

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| **Section 6: REFERRER DETAILS** |

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| --- | --- | --- | --- | --- |
| Your name: | |  | | |
| Service/Organisation: | |  | | |
| Designation: | |  | | |
| Telephone: |  | | Fax: |  |
| Email: |  | | | |

**If you have any queries about your referral, please contact the office at 02 4720 8811 and we can discuss further.**

**Please email or fax this referral to:** [**yess@parramattamission.org.au**](mailto:yess@parramattamission.org.au) **/ (02) 8820 0737**

**The referring agent and applicant will be contacted within 5 business days after receipt of the referral to discuss the next steps.**