YESS YOUTH ENHANCED SUPPORT SERVICE

Parramatta Mission uniting church

SERVICE PROVIDER REFERRAL FORM

The Youth Enhanced Support Service/Karrikin (YESS) is for young people aged 12 to 25 who have, or are at risk of, developing a severe mental illness, and can be supported in the primary care setting. This includes young people who may require more than the support that headspace Primary Care is funded to provide, but who do not meet the relevant NSW Health Community Mental Health Services criteria.

Which region is this young person being referred to?

- ☐ Northern Sydney (Karrikin)
- ☐ Nepean Blue Mountains
- ☐ Western Sydney
- ☐ South Western Sydney

Please check the boxes below as a starting point to determine suitability for referral to YESS/Karrikin

- ☐ The young person has, or is at risk of developing, a severe mental illness
- ☐ Will require more than 10 treatment sessions, or has severe complex issues requiring case management
- ☐ Does not require more than 12 months of treatment
- ☐ Does not meet criteria for NSW Health Community or Child and Adolescent/Youth Mental Health Service
- ☐ Is not at immediate risk of harm to self or others. If the young person requires urgent assistance, please call the Mental Health Telephone Access Line on 1800 011 511 or dial 000.

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.

Important information about your referral:

- Please note that this form is intended for Service Providers who are involved in the young person's care. If you are seeking assistance for yourself, or are a family member or friend wanting to refer your loved one, please contact us directly on 1800 YESS PM (1800 9377 76)
- Please be aware that **receipt of the referral does not indicate acceptance** to the YESS service. 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 **1800 YESS PM (1800 9377 76),** or at **yess@parramattamission.org.au.**
- Information on this form will assist our team in determining suitability and with the assessment process. Therefore please complete this form with as much information as possible and provide any supporting clinical documentation available. 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.

Section 1: YOUNG PERSON DETAILS

First Name: _____ Last Name: _____

Gender: _____ Preferred Pronoun(s): _____

DOB: _____

School Name: _____ Student Year: _____

Country of Birth: _____ Parents' Country of Birth: _____

Preferred Language: _____ Language Spoken at Home: _____

Interpreter Needed: _____ Interpreter Language: _____

Phone Number: _____

Mobile Number: _____

Email Address: _____

Address: _____

Suburb: _____ Postcode: _____

Section 2: NEXT OF KIN

Full Name: _____

Relationship to Young Person: _____

Phone Number: _____

Do we have permission to speak to this person? ☐ YES ☐ NO

Section 3: HEALTH 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):*
☐ Antipsychotics ☐ Antidepressants ☐ Anxiolytics ☐ Hypnotics/sedatives ☐ Other

Section 4: CURRENT AND HISTORIC SUPPORT DETAILS

Is the Young Person currently, or have they previously been, engaged with any of the following:

Please note: YESS works routinely with community GPs to coordinate care and at times, offer telepsychiatry appointments. In order for this service to be accessible, please ensure the relevant GP information and associated consent is outlined below.

Care Provider Type	Please Select	Name	Contact Details	Consent to Liaise - tick if yes
General Practitioner				
School Counsellor				
Private Psychologist				
Psychologist – Assess Plus or Mental Health Care Plan				
Homelessness Provider				
Public Mental Health Service				
Psychiatrist				
Child Protection Agency				
Drug and Alcohol Service				
Employment Service				
Other				

Section 5: DEMOGRAPHICS

Does the Young Person Identify as:

- ☐ Aboriginal
- ☐ Aboriginal and Torres Strait Islander
- ☐ Torres Strait Islander
- ☐ Neither

Marital Status:

- ☐ Never married
- ☐ Separated
- ☐ Married (registered and de facto)
- ☐ Divorced
- ☐ Widowed

Housing Status:

- ☐ Owned Home
- ☐ Private Rental
- ☐ Social Housing Aboriginal
- ☐ Boarding House
- ☐ Community Housing
- ☐ Public Housing
- ☐ Emergency Housing
- ☐ Homeless

Living Arrangement:

- ☐ Lives with parent(s)/guardian(s)
- ☐ Lives with partner
- ☐ Lives alone
- ☐ Lives with children
- ☐ Lives with other family

Employment Status:

- ☐ Full-time employment
- ☐ Part-time employment
- ☐ Casual employment
- ☐ Studying at school
- ☐ Unemployed
- ☐ Studying at university/TAFE
- ☐ Not in labour force

Income Source:

- ☐ N/A – not in labour force
- ☐ Compensation payments
- ☐ Paid employment
- ☐ Other
- ☐ Disability Support Pension
- ☐ Nil income
- ☐ Other pension or benefit

NDIS Involvement?

☐ Yes ☐ No

Continuity of Support Client?

☐ Yes ☐ No ☐ Unknown

Section 6: 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 taking and/or impulsive behaviour? ☐ Yes ☐ No

Details:

Section 7: ADDITIONAL INFORMATION

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

Section 8: REFERRING AGENT DETAILS

For GPs in the Nepean Blue Mountains regions, please tick if interested in telehealth consultation with our Consultant Psychiatrist, and provide contact details below to coordinate telehealth session ☐

Referring Agent Name: _____

Service/Organisation: _____

Designation/Profession: _____

Telephone: _____ Fax: _____

Email: _____

Please send this referral to:

Email: yess@parramattamission.org.au

Fax: 02 8820 0737

The referring agent will be contacted within 3 business days after receipt of the referral to discuss the next steps.