MATT Joondalup
T: (08) 9301 8999
F: (08) 9301 0859
E: earlypsychosisReferral@headspacejoondalup.com.au

headspace Early Psychosis Referral Form

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.

Please check the referral criteria below.

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 YOUNG PEOPLE / FAMILIES / OTHER REFERRERS

Use of this referral form is optional. Referral may be made by letter, email, phone, or walk-in to a headspace Early Psychosis centre. It is okay if you can't fill out the whole form, just give as much information as you can. If you're not sure of anything, give us a call.

INCLUSION CRITERIA

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

EXCLUSION CRITERIA

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

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*Ultra-High Risk

Decline in functioning or persistent low functioning in combination with at least **one** of the following:

1. Attenuated psychotic symptoms
2. Brief limited intermittent psychotic symptoms (BLIPS)
3. Trait vulnerability for psychotic illness (schizotypal personality disorder or a family history of psychosis)

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YOUNG PERSONS DETAILS		
Name:		
Address:		
DOB:	Gender:	Preferred Pronouns:
Mobile:	Home:	
Cultural Identity:	Language:	Interpreter required: ☐ Yes ☐ No
Indigenous / Cultural Identity: Does the YP identify as: ☐ Yes ☐ No Aboriginal ☐ Yes ☐ No Torres Strait Islander ☐ Prefer not to answer		

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

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Current thoughts / plans / intent? If Yes, Details:	☐Yes ☐No
History of risk from others? If Yes, Details:	☐Yes ☐No
Current thoughts / plans / intent? ☐Yes ☐No 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 (*What are the interim arrangements for the care of this young person pending outcome of referral?)*

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:**