



Youth Enhanced Service – Referral Form

The Youth Enhanced Service is here to assist young people aged 12-25 years with moderate to high mental health care needs.

Eligibility Criteria:

Young person is aged between 12 and 25 years	Age:	
Young person resides in the following Local Government Areas (LGA) of Salisbury Playford, Marion, Onkaparinga, Port Adelaide Enfield, or Adelaide.	LGA:	
Severe mental health symptoms (as demonstrated by IAR Level 4+ or biopsychosocial assessment). <i>(Please refer to the Australian Dept of Health, National Initial Assessment and Referral for Mental Healthcare Guidance, 2019 or https://iar-dst.online)</i>	IAR level:	
	IAR attached?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Severe psychological distress.	Detailed below?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Functional impairment in at least two areas of life (including suicide risk and co-occurring condition).	Detailed below?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Exclusion Criteria:

Provide further info if wanting to be assessed for exception:

Engaged with another Commonwealth funded service.	<input type="checkbox"/> NDIS	
	<input type="checkbox"/> hEP	
	<input type="checkbox"/> Community mental health team (LHN or CAMHS)	
	<input type="checkbox"/> Private practitioner (MBS)	
Primary presentation is related to a neurodevelopmental disorder that is unaccompanied by a complex mental health presentation.	<input type="checkbox"/> ADHD	
	<input type="checkbox"/> ASD	
	<input type="checkbox"/> Intellectual disability	
	<input type="checkbox"/> Other	

Referrer's Details

Name:		Organisation:	
Role:		Phone:	
Address:			
Email*:			
<i>* To receive notification that this referral has been received, an email address is required.</i>			
Please provide details regarding current and previous level of support provided:			

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Young Person's Details			
Legal full name:			
Preferred name:		Pronouns:	
Gender identity:		Sex at birth:	
Date of birth:		Phone:	
Address:			
Email:			
First Nations:	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander		
Interpreter required?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Language: (If 'Yes')	

Support Person's Details (e.g. parents, guardians etc)	
Full name:	
Relationship:	
Phone:	
Email:	

Biopsychosocial Health Information	
Current presenting issues and symptoms: (incl onset, severity, duration)	
Formal diagnoses:	
Co-existing conditions and impact:	
Functioning capacity: (incl work/study, hygiene, ADLs, accommodation)	
Physical health concerns: (incl eating, sleep)	

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Biopsychosocial Health Information	
Social and environmental stressors:	
Service and treatment: <i>(incl current and previous)</i>	
Discharge plan from mental health service <i>(if available)</i> attached:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Risk Assessment <i>(include details of current & previous):</i>	
Suicidal ideation:	
Non-suicidal self-injury:	
Safety plan attached?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vulnerabilities:	
Substance use:	
Previous mental health services history:	

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Risk Assessment <i>(include details of current & previous):</i>	
Medication: <i>(incl prescription, dosage, adherence)</i>	
Protective factors:	
Family or community supports in place:	

Goals	
Goals within YES:	
Barriers: <i>(incl strategies to overcome)</i>	

Consent for referral			
<i>By signing this form, the young person is aware of, and gives consent to, this referral. For those under 16 years of age, a parent/caregiver is required to sign.</i>			
Young person's signature:		Date:	
Parent/caregiver's signature:		Date:	
Referrer's signature:		Date:	

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