# Youth Enhanced Service – Referral Form

| Please indicate your service | | | |
|---|---|---|---|
| ☐ CAHMS/Adult MH Service | ☐ headspace | ☐ GP | ☐ Other |
| ***Head to Health is an alternative entry point – 1800 595 212*** | | | |

| **Referral Criteria** *(eligibility may be dependent on the following criteria:)* | |
|---|---|
| Young person is aged between 12 and 25 years | ☐ Yes ☐ No |
| Young person resides in the following Local Government Areas of Salisbury, Playford, Marion, Onkaparinga, Port Adelaide Enfield and Adelaide. | ☐ Yes ☐ No |
| Severe mental health symptoms (as demonstrated by IAR Level 4 or biopsychosocial assessment)<br>(Please refer to the Australian Dept of Health, National Initial Assessment and Referral for Mental Healthcare Guidance, 2019 or https://iar-dst.online) | ☐ Yes ☐ No |
| Severe psychological distress | ☐ Yes ☐ No |
| Functional impairment in at least two areas of life (including suicide risk and co-occurring condition).<br>If yes, can you name them: | ☐ Yes ☐ No |
| Is there currently an NDIS plan in place for the young person? | ☐ Yes ☐ No |

| **Referrer's Details** | | | |
|---|---|---|---|
| Referrer name: | | Role: | |
| Address: | | | |
| Phone: | | | |
| Email*: | | | |
| * *To receive notification that this referral has been allocated, an email address is required.* | | | |

| **Young Person's Details** | | | |
|---|---|---|---|
| Full name: | | | |
| Preferred name: | | Date of birth: | |
| Gender: | | Pronouns: | |
| Address: | | | |
| Phone: | | | |
| Email: | | | |
| Interpreter required? | ☐ Yes ☐ No | Language: *(If 'Yes')* | |

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

| Medical and General Health Information | |
|---|---|
| Diagnoses: | |
| Medications: | |
| Previous mental health services history: | |
| Current symptoms and duration (**must** have been present for six or more months): | |
| Current risks: | |
| NSSI and SH history: | |
| Copy of current safety plan (if available) attached: | ☐ Yes ☐ No |

| Medical and General Health Information | |
|---|---|
| General functioning capacity: | |
| Impact of co-existing conditions: | |
| Previous treatment and recovery history: | |
| Social and/or environmental stressors: | |
| Family or community support in place: | |
| MHTP (if available) attached: | ☐ Yes ☐ No |
| Discharge plan from mental health service (if available) attached: | ☐ Yes ☐ No |
| Other notes: | |

| Consent for referral | |
|---|---|
| *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.* | |
| Young person's signature: | |
| Parent/caregiver's signature | |
| Referrer's signature: | |