REFERRAL INFORMATION FOR THE YOUTH MENTAL HEALTH PROGRAM

Thank you for your enquiry regarding a referral to the Youth Mental Health Program which comprises three specialist mental health services: YouthLink, YouthReach South and Youth Axis.

YOUTHLINK AND YOUTHREACH SOUTH

YouthLink and YouthReach South are specialist youth mental health services providing Tier 4 mental health services to young people with serious mental health problems or at significant risk of developing serious mental health problems. Tier 4 is defined as a highly specialised treatment program for complex, severe or persistent problems.

Both services target marginalised young people aged 13 to 24 years, who are homeless or experiencing other significant barriers in accessing mainstream mental health services. Such barriers typically include transience, limited support networks, cultural barriers including Aboriginal or Torres Strait Islander identity, marginalisation due to diverse sexuality and gender, and previous negative treatment experiences.

YOUTH AXIS

Youth Axis provides an early intervention service for young people presenting with ultra-high risk of psychosis and/or features of an emotionally unstable personality disorder. Youth Axis targets young people who have not had extensive treatment by a specialist mental health service for these presenting problems, and will see people for up to 6 months. The following criteria must be met to be eligible for service:

1. *The young person is residing in stable accommodation in the Perth Metropolitan area.*
2. *16 to 24 years old.*
3. *Help accepting.*

And one or more of the following:

1. *Ultra-high risk of psychosis. Unusual and out of character thoughts and /or behaviour.*
2. *Features of an emotionally unstable personality disorder:*
    - *suicidal ideation and/or self-harming*
    - *risk taking / impulsivity*
    - *emotional instability*
    - *impaired sense of self*
    - *impairment in interpersonal functioning*
    - *separation insecurity: fears of abandonment by significant others*

Exclusion Criteria:

- *Continual psychotic symptoms for more than 7 days;*
- *Needs are better met by another service.*

The Youth Mental Health Program is unable to provide an urgent response to unknown clients.

YOUTH MENTAL HEALTH PROGRAM (YMHP) – REFERRAL FORM

YMHP community services consist of three services: YouthLink, YouthReach South and Youth Axis. YouthLink and YouthReach South provide services to young people13-24 years with mental health issues who experience significant barriers in accessing mental health care, including homelessness. Youth Axis provides time limited focused care for young people from 16-24 years at ultra-high risk of psychosis or emerging emotionally unstable personality disorder – borderline type. This referral form will assist in streaming the young person to the service that will best fit their needs.

Youth Axis	YouthLink	YouthReach South
32 - 34 Salvado Road, Wembley. 6014 Tel: 9287 5700 Fax: 9287 5760	223 James Street, Northbridge. 6003 Tel: 9227 4300 Fax: 9328 5911	Level 1 / 25 Wentworth Parade, Success. 6164 Tel: 9499 4274 Fax: 9499 4270

Triage Telephone line: 1300 362 569 Email referral to: youthmhtriage@health.wa.gov.au Fax Number: 9287 5762

YOUNG PERSON PERSONAL INFORMATION

Date of Referral:	UMRN:	
Forenames	Surname	Preferred Name
Address		D.O.B._____/_____/_____
Telephone Preferred mode of contact Call ☐ Text ☐	Aboriginal/Torres Strait Islander:	Country of Birth: Ethnicity:
Sex assigned at birth Male ☐ Female ☐	Gender Identity:	
Any language, cultural or sensory requirements? ☐ Interpreter required ☐ Language spoken		Other requirements?

IS THE YOUNG PERSON (A response of NO does not preclude the young person from the YMHP community service)

Between 13 and 15 years old? Yes ☐ No ☐	Significant decline in education or work performance over the past year? Yes ☐ No ☐ Unknown ☐
Between 16 and 24years old? Yes ☐ No ☐	Psychotic symptoms for more than 7 days or diagnosed with psychosis? Yes ☐ No ☐ Unknown ☐
If under 18, a parent or guardian consents to the referral? Yes ☐ No ☐	Active treatment of more than 6 months with a mental health service? Yes ☐ No ☐ Unknown ☐
If under 18, is considered a mature/ minor? Yes ☐ No ☐ Unknown ☐	Decline in self-care, living skills or relationships over the past year? Yes ☐ No ☐ Unknown ☐
	Experiencing difficulty or barriers accessing mental health services? Yes ☐ No ☐ Unknown ☐
	Out of character thoughts and/or behaviour over the pastyear? Yes ☐ No ☐ Unknown ☐

NEXT OF KIN / GUARDIAN: Relationship: Parent ☐ Legal Guardian ☐ Partner ☐ Next of Kin ☐ Nominated Person ☐ Other ☐
Surname: First Name:

Address:

Contact Telephone Number:

REASON FOR REFERRAL (Attach any additional information)

MENTAL HEALTH ISSUES (Attach any additional information)

CURRENT RISK / SAFETY ISSUES Please indicate the level of risk for the following:

Suicide: Low ☐ Medium ☐ High ☐ Unknown ☐ Self-harm: Low ☐ Medium ☐ High ☐ Unknown ☐

Violence to others: Low ☐ Medium ☐ High ☐ Unknown ☐ Vulnerable to exploitation: Low ☐ Medium ☐ High ☐ Unknown ☐

Justice/ legal issues: None ☐ Previous ☐ Current ☐ Unknown ☐

Please detail historical and current risk/ safety issues

SUBSTANCE USE Tobacco ☐ Alcohol ☐ Cannabis ☐ Amphetamines ☐ Inhalants ☐ Prescription ☐ Opioids ☐ Cocaine ☐ Other ☐ (specify below)

Please specify quantity, duration and impact of use if known

FAMILY / DEVELOPMENTAL HISTORY (Attach any additional information)

LIVING / SOCIAL SITUATION Current living situation: Secure ☐ Tenuous ☐ Homeless ☐

Accommodation type: Living with family ☐ Crisis Accommodation ☐ Hostel Accommodation ☐ Rental with friends ☐ CPFS placement ☐ Couch surfing ☐ Rental alone ☐ Rental with others ☐ Supported accommodation ☐ Transient ☐ Homeless ☐

Please describe social / peer / relationships and supports

EDUCATION HISTORY Current status: Full Time Student ☐ Part Time Student ☐ Enrolled, but not attending ☐ Online Studies ☐ Not currently studying ☐

WORK HISTORY Current status: Full-Time Work ☐ Part-Time Work ☐ Casual Work ☐ Unemployed ☐ Never Worked ☐

MEDICAL HISTORY Does the young person have any ongoing illnesses or conditions? ☐(specify below)
(Attach any additional information)

CURRENT MEDICATIONS

Medications	Dose/ frequency	Date commenced / Duration of use

Any further details:

OTHER SIGNIFICANT CONTACTS/ SERVICES INVOLVED

Contact Person	*ADDRESS*	*Telephone*
USUAL GP-		

Please identify any supporting documentation/ reports included with referral Medical assessment ☐ Risk assessment ☐ Functional assessment ☐
Discharge summary ☐ Care plan ☐ Educational Assessment ☐ Psychological Assessment ☐ Other ☐ (please specify)

Any further Information?

REFERRER DETAILS Name: Position: Contact Number:

Agency: / Address:

OFFICE USE ONLY

Date Referral Received:	Date Triaged:	Triaged by:
Date Presented:	Outcome of Referral:	Referred on to: