**Youth Plus Referral Form**

Once completed please email to: hs.Lithgow@marathonhealth.com.au

**Do you believe this young person is at risk of harm to themselves or other people?**  Yes  No

Youth+ Clinic is an early intervention and prevention service. If the young person is at risk of harm to themselves or to someone else, they are no suitable for headspace services. Please contact the mental health hotline on 1800 011 511 (24 hours) for appropriate services, take them to your nearest hospital, or call 000.

The Youth+ Clinic is a brief intervention service that offers young people 12-25 years old, in crisis, a **set of specific individual appointments**. During these sessions, a clinician will talk with the young person and provide support, help navigate their way through the crisis, and link them into further services as needed.

**Criteria for the Youth+ service**

* Has not had more than 6 months of previous psychological treatment for the presenting issue
* Willing to engage in weekly sessions
* Thoughts and feelings of suicide and self-harm
* Impulsive and/or self-destructive behavior
* Changing in emotions and strong, overwhelming feelings
* Is aged between 12 and 25
* Does not meet criteria for NSW Community Health or Child and Adolescent/Youth Mental Health Service

**Exclusion criteria……**

* Evidence of psychosis, disordered eating, primary alcohol/drug dependence disorder, suicidal ideation with plan or intent, significant current self-harm or risky behavior.
* Complex issues requiring case management

Please note that receipt of the referral does not indicate acceptance to the Youth+ Clinic. 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 6352 7600 or at [hs.Lithgow@marathonhealth.com.au](mailto:hs.Lithgow@marathonhealth.com.au) and we can discuss further.

\*\*Please complete this form with as much information as possible and provide any supporting clinical documentation available as this will assist our team in determining suitability and the assessment process. 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.

**Client information….**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Young persons preferred name: | | |  | | | | | | | |
| Young persons last name: | | |  | | | | | | | |
| Are they known by any other names: | | |  | | | | | | | |
| date of birth: | | |  | | | | age: | | |  |
| gender: | | |  | | | | pronouns: | | |  |
| Phone number: | | |  | Email (optional): | |  | | | | |
| Indigenous/Cultural Identity: | | Aboriginal | | | Torres Strait Islander | | | Both | Non-Indigenous | |
| Residential address: | | | Street:  Suburb: | |  | | Postcode: | | | |
| Who with? | At home with family  Living alone  Homeless  Staying with friends  supported accommodation  Refuge | | | | | | | | | |

**Next of Kin….**

|  |  |
| --- | --- |
| Full name: |  |
| Relationship to young person: |  |
| Contact number: |  |
| Do we have permission to speak with this person: | yes  no |

**Referral information….**

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

|  |  |
| --- | --- |
| best person to contact about this referral: | Young person  Parent/Guardian  Referrer |

**Current and Historic support details….**

|  |  |  |  |
| --- | --- | --- | --- |
| **Care Provider type** | **Name** | **Contact details** | **Consent to Liaise?** |
| General Practitioner |  |  |  |
| School Counsellor |  |  |  |
| Private Psychologist |  |  |  |
| Homelessness Provider |  |  |  |
| Psychiatrist |  |  |  |
| Child protection Agency |  |  |  |
| D&A services |  |  |  |
| NDIS Involvement |  |  |  |
| Other |  |  |  |

**Safety considerations (please note these are not exclusion criteria)….**

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| --- |
| **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 talking and/or impulsive behaviour?**  yes  no  Details: |

**Referrers details….**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | |  |
| Position / Organization: |  | |  |
| Email: |  | |  |
| Best contact number: |  |  | |
| Address: |  | | |

**Consent….**

|  |
| --- |
| **Please note that for headspace Lithgow to accept this referral:**   * The young person is aged between 12 and 25 years of age * The young person consents to this referral * We require consent of the young person or parent/guardian if under the age of 16.   If this is not possible, please get in touch and we’ll talk you through some other options. |
| **Young Person**  I am aware of and consent to this referral being made.  I understand that I can withdraw from this referral or from the referred service at any time.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ Client name Client signature Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ Parent/Guardian name Parent/Guardian signature Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ **Referrer name Referrer signature Date** |