



MATT and Joondalup
 Tel: (08) 9301 8999
 Fax: (08) 9301 0859
 Email: earlypsychosisReferral@headspacejoondalup.com.au

headspace Early Psychosis Referral

The Mobile Assessment and Treatment Team will conduct a comprehensive biological, social and psychological assessment with the young person, whilst considering the inclusion/exclusion criteria of the service and what the most appropriate long-term service for the young person will be. A decision as to acceptance into headspace Early Psychosis for ongoing continuing care and case management will be made at the end of the assessment process.

Inclusion Criteria:

- Aged 12-25 years
- Diagnosis of psychosis or of ultra high risk of psychosis (characterized by attenuated psychotic symptoms, brief limited psychotic symptoms, or trait vulnerability, and deterioration in functioning/persistent low functioning).

Exclusion Criteria:

- Under the age of 12 years or over the age of 25 years at time of referral
- More than 12 months of treatment for psychosis by another mental health service
- Symptoms present only in the context of substance intoxication
- More likely to benefit from another service or program.

Inclusion of additional information (triage notes, discharge summaries, medication charts, etc.) will be helpful in the assessment process. **Note:** headspace is a non-government organisation that does not have access to Government records, this includes PSOLIS.

YOUNG PERSON DETAILS	
Name:	
Address:	
DOB:	Gender:
Contact numbers:	Mobile: Home: ()
Indigenous / Cultural Identity:	Interpreter required: Yes <input type="checkbox"/> No <input type="checkbox"/>
	Language:
IMPORTANT CONTACT DEATILS	
Next of Kin / Emergency Contact:	PH:
General Practitioner:	PH:
GP Practice:	PH:
REFERRER DETAILS	
Name:	Organisation / Position:
Address:	Email:
	Phone:
	Fax:



MATT and Joondalup
Tel: (08) 9301 8999
Fax: (08) 9301 0859
Email: earlypsychosisReferral@headspacejoondalup.com.au

REASON FOR REFERRAL	
Presenting issues:	
CURRENT MENTAL HEALTH SYMPTOMS	
DURATION OF SYMPTOMS	
When was this young person first recognised to have the identified presenting issues:	
Details:	
History of prodromal symptoms? Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/>	
Estimated length of Duration of Untreated Psychosis (DUP)?	
Evidence of negative symptoms? Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/>	
How have the mental health issues impacted on functioning?	
Details:	
Level of Insight (please select box)	
<input type="checkbox"/> Excellent: understands diagnosis and need for treatment	



MATT and Joondalup
Tel: (08) 9301 8999
Fax: (08) 9301 0859
Email: earlypsychosisReferral@headspacejoondalup.com.au

- Moderate: accepts something is wrong and willing to accept treatment
- Poor: accepts something is wrong,, but is unwilling to accept treatment
- Insightless: does not perceive self as having an illness

TREATMENT HISTORY – MENTAL HEALTH

Previous contact with other mental health services or private practitioners? Yes No Unknown
Details:

Previous psychiatric diagnoses? Yes No Unknown
Details:

Previous hospitalisations? Yes No Unknown
Details:

Previous medications? Yes No Unknown
Details:

Current medications? Yes No Unknown
Details:

MEDICAL HISTORY

Are there any physical health issues / illnesses? Yes No Unknown
Details:

Have recent investigations been completed (i.e, baseline bloods including metabolic, ECG, CT / MRI Head)?

Relevant findings / date completed:

FAMILY PSYCHIATRIC HISTORY (mental illness/addiction/suicide)

SOCIAL SITUATION (family relationships, level and nature of supports, accommodation, study / employment, finances)

SUBSTANCE USE (type and amount / frequency)



MATT and Joondalup
Tel: (08) 9301 8999
Fax: (08) 9301 0859
Email: earlypsychosisReferral@headspacejoondalup.com.au

History: Yes No Current: Yes No

Details:

FORENSIC ISSUES

History of Criminal Charges: Yes No
Details:

Current or Pending Charges / Issues: Yes No
Details:

RISK ASSESSMENT

History of self-harm / suicidality? Yes No
Yes No

Current thoughts / plans / intent:

Details:

History of violence? Yes No
Current thoughts / plans / intent: Yes No
Yes No

Details:

History of risk from others? Yes No

Details:

MENTAL HEALTH ACT STATUS

Voluntary / Involuntary

Community Treatment Order: Yes No Expiry Date ____ / ____ / ____

OTHER SERVICES INVOLVED

Are there any other support services involved with the young person? Yes No

Details:

INTERIM PLAN (What interim arrangements are in place for care of this young person pending outcome of referral?)



MATT and Joondalup
Tel: (08) 9301 8999
Fax: (08) 9301 0859
Email: earlypsychosisReferral@headspacejoondalup.com.au

IS THE YOUNG PERSON AWARE OF THE REFERRAL? Yes No

IS THE YOUNG PERSON AGREEABLE TO REFERRAL? Yes No

Signature: _____ Date Referral Received: _____