MATT Joondalup
T: (08) 9301 8999
F: (08) 9301 0859
E: earlypsychosisReferral@headspacejoondalup.com.au

headspace Early Psychosis Referral Form

headspace Early Psychosis is a comprehensive, early intervention mental health service for young people experiencing psychosis or who are at Ultra-High Risk (UHR) of psychosis.

Please check the referral criteria below.

FOR TERTIARY SERVICES

You may send your own assessments, as well as risk assessments, in lieu of this form. Please note as we are a non-government organisation, we do not have access to government records, including PSOLIS. Please call if you have any queries.

FOR YOUNG PEOPLE / FAMILIES / OTHER REFERRERS

Use of this referral form is optional. Referral may be made by letter, email, phone, or walk-in to a headspace Early Psychosis centre. It is okay if you can't fill out the whole form, just give as much information as you can. If you're not sure of anything, give us a call.

INCLUSION CRITERIA

- Aged 12-25 (inclusive) at time of referral
- Diagnosis of psychosis or Ultra-High Risk* of psychosis
- Within catchment areas (North and East Metropolitan Perth)

EXCLUSION CRITERIA

- More than 24 months of medical treatment for psychosis by another service/practitioner
- Symptoms only present when acutely intoxicated
- More likely to benefit from another service or program

---

*Ultra-High Risk

Decline in functioning or persistent low functioning in combination with at least **one** of the following:

1. Attenuated psychotic symptoms
2. Brief limited intermittent psychotic symptoms (BLIPS)
3. Trait vulnerability for psychotic illness (schizotypal personality disorder or a family history of psychosis)

MATT Joondalup
T: (08) 9301 8999
F: (08) 9301 0859
E: earlypsychosisReferral@headspacejoondalup.com.au

YOUNG PERSONS DETAILS		
Name:		
Address:		
DOB:	Gender:	Preferred Pronouns:
Mobile:	Home:	
Aboriginal / Torres Strait Islander: Yes ☐ No ☐ Prefer not to answer ☐	Language: Cultural Identity: Interpreter required: Yes ☐ No ☐	

IMPORTANT CONTACTS	
Next of Kin / Emergency Contact: Relationship:	Ph:
General Practitioner: GP Practice:	Ph:

REFERRER DETAILS	
Name:	
Organisation:	Position:
Address:	
Phone:	Email:

REASON FOR REFERRAL *(e.g., when did issues begin, impact on school/work, duration and frequency of symptoms)*

LEVEL OF INSIGHT

- ☐ Excellent: understands diagnosis and need for treatment
- ☐ Moderate: accepts something is wrong and willing to accept treatment
- ☐ Poor: accepts something is wrong, but is unwilling to accept treatment
- ☐ None: does not perceive self as having an illness

MATT Joondalup
T: (08) 9301 8999
F: (08) 9301 0859
E: earlypsychosisReferral@headspacejoondalup.com.au

MENTAL HEALTH HISTORY	
Previous contact with mental health services/private practitioners? Details:	Yes ☐ No ☐
Previous psychiatric diagnoses? Details:	Yes ☐ No ☐
Previous hospitalisations? Details:	Yes ☐ No ☐
Previous medications? Details:	Yes ☐ No ☐
Current medications? Details:	Yes ☐ No ☐

MEDICAL HISTORY	
Are there any physical health issues? Details:	Yes ☐ No ☐ Unknown ☐
Have any recent investigations been completed (i.e, blood tests, ECG, CT/MRI)? Details:	Yes ☐ No ☐ Unknown ☐ If Yes, date completed:

FAMILY PSYCHIATRIC HISTORY
Is there any family history of mental illness? Details:

MATT Joondalup
T: (08) 9301 8999
F: (08) 9301 0859
E: earlypsychosisReferral@headspacejoondalup.com.au

SOCIAL SITUATION *(family relationships, level of support, accommodation, study, employment, finances)*	
SUBSTANCE USE	
History of use? Yes ☐ No ☐ Unknown ☐	Current use? Yes ☐ No ☐ Unknown ☐
Details:	
FORENSIC HISTORY	
History of criminal charges? Details:	Yes ☐ No ☐ Unknown ☐
Current or pending charges? Details:	Yes ☐ No ☐ Unknown ☐
RISK ASSESSMENT	
History of self-harm / suicidality?	Yes ☐ No ☐
Current thoughts / plans / intent? Details:	Yes ☐ No ☐
History of violence?	Yes ☐ No ☐
Current thoughts / plans / intent? Details:	Yes ☐ No ☐
History of risk from others?	Yes ☐ No ☐
Current thoughts / plans / intent? Details:	Yes ☐ No ☐
MENTAL HEALTH ACT STATUS	
If in hospital	Voluntary ☐ Involuntary ☐
Community Treatment Order? Yes ☐ No ☐	Expiry Date:

MATT Joondalup
T: (08) 9301 8999
F: (08) 9301 0859
E: earlypsychosisReferral@headspacejoondalup.com.au

OTHER SERVICES INVOLVED	
Are there any other services involved with the young person? Details:	Yes ☐ No ☐
INTERIM PLAN (*What are the interim arrangements for the care of this young person pending outcome of referral?)*	
CONSENT	
hEP is a voluntary service, unless the young person is under the Mental Health Act or has a Community Treatment Order in place. ***Please ensure the young person is aware of, and consenting to the referral***	

IS THE YOUNG PERSON AWARE OF THE REFERRAL? Yes ☐ No ☐

IS THE YOUNG PERSON AGREEABLE TO REFERRAL? Yes ☐ No ☐

Signature: **Date referral received:**