

PROVISIONAL REFERRAL FOR: YOUNG PEOPLE (12-25 years old) Psychological Support Services (PSS)



This form is required to refer young people (12- 25 years old) who are experiencing mild to moderate mental health concerns and for whom available services (including Medicare subsidised services) are not suitable, for assessment and short term psychological intervention.

THIS IS NOT A CRISIS SERVICE, if crisis assistance is required, please call the Mental Health Access Line on **1800 011 511**

Eligible Provisional Referrers Include: School Counsellors and School Principals/Deputies.			
Please Note: This referral is for <u>two (2) FREE provisional sessions only</u> ; a combined GP Initial PSS referral and Mental Health Treatment Plan is required to approve further sessions.			
SUBMIT COMPLETED REFERRALS via SECURE FAX: (02) 9330 9988 or HEALTHLINK ID: CESPNNMH			
DATE OF REFERRAL		/ /	
Program Eligibility (please check each item - patient must meet each criteria below to be referred)			
<input type="checkbox"/> Young person lives, works or goes to school in the Central and Eastern Sydney region			
<input type="checkbox"/> Young person has NOT accessed Medicare rebated psychological services this <u>calendar year</u> under Better Access			
<input type="checkbox"/> Young person is unable to access other available services, including Better Access			
<input type="checkbox"/> Young person is experiencing mild to moderate mental illness			
<input type="checkbox"/> Young person would benefit from short term psychological intervention			
<input type="checkbox"/> Young person is not better suited to a crisis or specialist domestic violence services and is not involved in court or insurance matters			
<input type="checkbox"/> Young person is aged 12 – 25 years old			
REFERRER DETAILS			
Name		Position	
Organisation Name		Postcode	
Phone		Fax	
E-mail			
<i>*** please note that if an e-mail address is not provided you will not receive referral confirmation.</i>			
CLIENT DETAILS			
First Name		Last Name	
Date of Birth			
Marital Status	<input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married/De facto		
Current Gender Identity	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Different Identity		
Address			
Suburb		Postcode	
Phone 1		Phone 2	
Healthcare Card	<input type="checkbox"/> Yes <input type="checkbox"/> No	NDIS Participation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aboriginal and/or Torres Strait Islander	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither <input type="checkbox"/> Unknown		
Country of Birth		Cultural Identity	
Main language spoken at home			
Proficiency in spoken English	<input type="checkbox"/> Very well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at all		

For referral information or support please contact CESPNN Mental Health Intake on: Phone (02) 9330 9999

MENTAL HEALTH SELF-ASSESSMENT TOOL (to be completed by patients over 16 years old)

K10+ (please note, this is an updated version of the K10 - questions 11-14 are excluded from total score)

In the last 4 weeks:		None of the time	A little of the time	Some of the time	Most of the time	All of the time	Not stated / Missing
1	about how often did you feel tired out for no good reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	about how often did you feel nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	about how often did you feel so nervous that nothing could calm you down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	about how often did you feel hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	about how often did you feel restless or fidgety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	about how often did you feel so restless you could not sit still?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	about how often did you feel depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	about how often did you feel that everything was an effort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	about how often did you feel so sad that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	about how often did you feel worthless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TOTAL SCORE							
11	how many days were you totally unable to work, study or manage your day to day activities because of these feelings?	(Number of Days)					
12	aside from those days, in the past four weeks, how many days were you able to work or study or manage your day to day activities, but had to cut down on what you did because of these feelings?	(Number of Days)					
13	how many times have you seen a doctor or any other health professional about these feelings?	(Number of Consultations)					
14	how often have physical health problems been the main cause of these feelings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CO-MORBID ISSUES

Please indicate if the young person has any of the below co-morbid issues

- | | |
|---|---|
| <input type="checkbox"/> Chronic physical illness | <input type="checkbox"/> Personality issues |
| <input type="checkbox"/> Drug and alcohol issues | <input type="checkbox"/> Psychosocial stressors |
| <input type="checkbox"/> Intellectual disability | <input type="checkbox"/> Suicidality |
| <input type="checkbox"/> Psychiatric co-morbidity | |

DESCRIPTION OF PRESENTING COMPLAINT(S)/PROBLEM(S): Please provide as much information as possible (e.g. psychological/emotional/behavioural/physical/social problems)
N.B. Please attach additional information or copies of assessments if available.

RISK ASSESSMENT: If risk is high please refer to the Mental Health Access Line on: **1800 011 511**

Suicidal thoughts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicidal intent	<input type="checkbox"/> Yes <input type="checkbox"/> No
Current plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recent self-harm	<input type="checkbox"/> Yes <input type="checkbox"/> No	Risk of harm from others	<input type="checkbox"/> Yes <input type="checkbox"/> No

YOUNG PERSON PREFERRED PSS PROVIDER NAME (Subject to availability and may be left blank):
 Directory available at <https://www.cesphn.org.au/PSS>

1.	
2.	

NEXT OF KIN

Name		Phone	
Relationship		Permission for CESP HN and/or Mental Health Professional to contact	<input type="checkbox"/> Yes <input type="checkbox"/> No

YOUNG PERSON CONSENT: *Referral cannot proceed without young person consent*

- Referrer confirms that the young person understands and consents to the following;
- The above Provisional Referral to be sent to CESP HN and understands that a GP Mental Health Treatment Plan is required to approve further sessions
 - That CESP HN collects and shares information within the requirements of the Privacy Act 1988, with the PSS Provider Organisation and treating Mental Health Professional
 - That their de-identified data will be used for reporting and evaluation purposes
 - That they will be contacted by the allocated PSS Provider Organisation or Mental Health Professional to arrange an appointment
 - That they may be contacted by CESP HN or its representative to complete a client experience of care survey Yes No

REFERRER SIGNATURE:		DATE:	/ /
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