# Youth Hospital in The Home (HiTH) Referral Form

#### Referrals will be processed 7 days a week between 8.30am and 5pm. Referrals should be discussed with the HiTH NUM on 0481 387 874 or 6152 9064. Please send information to FSH.MHYouthHiTHReferrals@health.wa.gov.au.

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| Patient Referral Information | | | | |
| **Date of referral:** | | | Click here | **Patient Details:** *affix patient sticker here*  **UMRN:** Click here  **DOB:** Click here  **Name:** Click here  **Address:** Click here  **Phone:** Click here |
| **Anticipated discharge date** *(Inpatients only*)**:** | | | Click here |
| **Gender:** | | | Click here |
| **Primary language and communication requirements:**  Interpreter required | | | | **Next of Kin/Guardian/Support person details:**  **Name:** Click here  **Phone:** Click here  **Relationship:** Click here |
| **Referral discussed with HiTH?** Yes  No  Name: Click here | | | |
| Youth HiTH Admission Requirements | | | | |
| Y  Y  Y  Y  Y  Y  Y  Y | N  N  N  N  N  N  N  N | Young person is between the age of 16 to 24 (16 to 17 year olds will be prioritised)  Young person has a mental health condition with an acute deterioration  Young person resides in South Metropolitan Health Service catchment area  Young person consents to admission and daily participation with HiTH  Young person has stable accommodation for the next 14 days  The home environment is suitable and safe for mental health care to be provided in the home  The risk of violence, aggression or self-harm can be managed in a community setting  Physical health co-morbidities have been assessed by a medical practitioner if appropriate | | |

## Referral Information

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| Referral Details |
| **Presenting problems requiring admission:** (summarise main points including allied health needs and include ICD-10 diagnosis if available)  Click here |
| **Medical history:** (include allergies, current treatments and any physical health requirements)  Click here |
| **CTO details:** (if applicable – include responsible psychiatrist and practitioner, CTO details and key dates)  Click here |
| **Details of other services involved or referrals made:** (e.g. Community Clinic, GP, NGOs)  Click here |
| **Current medications:**  Click here |

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| Provided Paperwork:please provide with referral if appropriate or tick if available | |
| **For services with who do not use PSOLIS please provide scanned copies of appropriate documentation. This may include but is not limited to:** | |
| Mental health assessment  Community visiting risk assessment tool  Recent MSE | Copies of last medical review from clinical notes  Care transfer summary  Physical health examination / COVID-19 vaccination status |
| **Available on PSOLIS, Best Practice or NACs:** please tick those which apply but do not send | |
| RAMP  Current care plan  Collaborative action plan  Recent triage documentation | Discharge summary  Medication list  CTO documents |
| Other, please list: Click here | |

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| Referrer Details | | | | | |
| **Referring clinical service:** Click here | | | | | |
| **Referrer name:** Click here | | | **Designation:** Click here | | |
| **Contact details:** Click here | | | | | |
| **Young person active with a mental health service?** | | Y/ N **Clinic**: | | Click here | |
| **Treating Doctor:** Click here | | | **Case manager:** Click here | | |
| **Name of referrer:** Click here | **Signature of referrer:** Click here | | | | **Date:** Click here |