

**REFERRAL INFORMATION FOR YOUTHREACH SOUTH**

Thank you for your enquiry regarding a referral to YouthReach South (YRS).

**YouthReach South**

YRS is a specialist youth mental health services providing Tier 4 mental health services to young people with serious mental health problems. Tier 4 is defined as a highly specialised treatment program for complex, severe or persistent problems.

The service targets marginalised young people aged 13 to 24 years, who are homeless or experiencing other significant barriers in accessing mainstream mental health services. Such barriers typically include transience, limited support networks, cultural barriers including Ab original or Torres Strait Islander identity, marginalisation due to diverse sexuality and gender.

YRS does not provide an urgent response to unknown clients. Waitlist times vary so consider if the Young Person being referred will require short-term intervention while awaiting service with YRS. To discuss waitlist times, please contact the YRS Triage Officer, Monday to Friday, 8.30am to 4.30pm.

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| **YOUTHREACH SOUTH – PAPER BASED REFERRAL FORM** | | | | | | | | | |
| **YouthReach South** Level 1 / 25 Wentworth Parade, Success. 6164  Co-located at Cockburn Youth Centre YRS Reception Telephone: 94314700Email referral to: YouthReachSouthTriage@health.wa.gov.auFax Number: 94994270 | | | | | | | | | |
| **REFERRER INFORMATION (required)** | | | | | | | | | |
| **Name:**  **Position:**  **Agency:**  **Contact Phone Number:**  **Contact Email:**  **I have discussed this referral with the young person and they consent to the referral: Yes** | | | | | | | | | |
| **YOUNG PERSON PERSONAL INFORMATION** | | | | | | | | | |
| **Date of Referral:** | | **UMRN:** | | | | | |  | |
| **First name(s):** | | **Surname:** | | | | | | **Preferred Name:** | |
| **Address:** | | | | | | | | **DOB:** | |
| **Telephone:**  **Preferred mode of contact:**  Call  Text | | **Aboriginal/ Torres Strait Islander:** | | | | | | **Country of Birth:**    **Religious/ cultural background:** | |
| **Sex assigned at birth:** | **Gender Identity:** | | **Sexuality:** | | | | **Pronouns:** |
| **Language spoken: Interpreter needed** ☐  **Any cultural requirements? Please describe:**  **Any sensory requirements? Please describe:** | | | | | | | | | |
| **IS THE YOUNG PERSON** (A response of NO does not preclude the young person from the YRS community service) | | | | | | | | | |
| **Between 13 and 15 years old?**  Yes No  **Between 16 and 24years old?**  Yes No  **If under 18, a parent or guardian consents to the referral?**  Yes No  **If under 18, is considered a mature minor?**  Yes No | | | | **Significant decline in education or work performance over the past year?**  Yes No  **Active treatment of more than 6 months with a mental health service?**  Yes No  **Decline in self-care, living skills or relationships over the past year?**  Yes No | | | | | |
| **NEXT OF KIN / LEGAL GUARDIAN**  **Name:**  **Relationship:**  **Contact number**  **Address** | | | | | **SUPPORT PERSON**  **Name:**  **Relationship:**  **Contact number**  **Address** | | | | |
| **REASON FOR REFERRAL (Mental health history and current presentation, biopsychosocial issues, neurodevelopmental issues, and barriers to accessing mainstream Mental Health Services)** – Attach any additional information. | | | | | | | | | |
| **CURRENT RISK / SAFETY ISSUES** Please describe the current risk for the following:  **Suicide:**  **Self-harm**  **Violence to others**  **Violence from others:**  **Vulnerable to exploitation:**  **Justice/ legal issues:** None Previous Current Unknown  Please describe: | | | | | | | | | |
| **Please describe significant historical risk/ safety issues:**  **Does the Young Person require short-term intervention or risk-management while on YRS waitlist?**  If yes, services arranged or involved:  If yes, current Safety Plan attached: | | | | | | | | | |
| **SUBSTANCE USE** Tobacco ☐ Alcohol ☐ Cannabis ☐ Amphetamines ☐ Inhalants ☐ Prescription ☐ Opioids ☐ Cocaine ☐  Other ☐ (specify below) | | | | | | | | | |
| **Please specify quantity, duration and impact of use, current or previous interventions, if known:** | | | | | | | | | |
| **FAMILY / DEVELOPMENTAL HISTORY** (Attach any additional information) | | | | | | | | | |
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| **LIVING / SOCIAL SITUATION**  **Accommodation type:** Living with family ☐ Crisis Accommodation ☐ Rental with friends ☐ Rental with others ☐ Rental alone ☐  CPFS placement ☐ Supported accommodation ☐ Couch-surfing ☐ Transient ☐ Homeless ☐ **Please describe how the young person perceives their living arrangement:****Please describe social / peer / relationships and supports:** | | | | | | | | | |
| **EDUCATION HISTORY Current status:** Full time student ☐ Part time student ☐ Enrolled, not attending ☐  Education facility attended:  Highest level of education attained:  Online studies ☐ Not currently studying ☐ | | | | | | | | | |
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| **WORK HISTORY Current status:** Full-time work ☐ Part-time work ☐ Casual work ☐ Unemployed ☐ Never worked ☐  **Hours worked per week?** | | | | | | | | | |
| **MEDICAL HISTORY Does the young person have any historical or current illnesses or conditions?**  **Specify:** | | | | | | | | | |
| **CURRENT MEDICATIONS** | | | | | | | | | |
| **Medications** | | **Dose/ frequency** | | | | **Date commenced / Duration of use/ Prescribed by whom** | | | |
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| **Any further details:** | | | | | | | | | |
| **OTHER SIGNIFICANT CONTACTS/ SERVICES INVOLVED** | | | | | | | | | |
| **Contact Person** | | **ADDRESS** | | | | | | | **Telephone** |
| **USUAL GP-** | |  | | | | | | |  |
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| **Please attach any supporting documentation/ reports.** | | | | | | | | | |