Goulburn Valley Health

HUME REGION EARLY PSYCHOSIS SERVICE

Early Psychosis Referral

Unit Record No: _____

Name: _____

Address: _____

Date of Birth: _____ Sex: Male / Female

Place Identification Label here

Name:	**D.O.B.:**
Address:	**Phone:** **Mobile:**
Referring Worker and Agency:	**G.P.** **Clinic :** **Phone :**
Next of Kin Details: **Relationship:** **Phone:**	**Interpreter required?** ☐ Yes ☐ No **Language:** **Special cultural considerations:**

Has the young person given consent for this referral? ☐ Yes ☐ No (Attach copy)
Are family/carers aware of referral? ☐ Yes ☐ No

Has this person been treated by Mental Health Services in the past? ☐ Yes ☐ No
If yes please give details: *(reason for treatment/who by/when/how long for/what medication used)*

Reason for Current Referral:

Please tick the box if any of the following are present:

Changes in behaviours:
- ☐ Sleep disturbance
- ☐ Appetite changes
- ☐ Withdrawn
- ☐ Isolating
- ☐ Erratic behaviour
- ☐ Increase in risk taking behaviour
- ☐ Suspicious/ paranoid

Changes in mood:
- ☐ Anxiety
- ☐ Depression
- ☐ Irritable
- ☐ Mood Swings
- ☐ Elevated/ manic
- ☐ Low motivation

Deterioration in functioning:
- ☐ Deterioration in Self care
- ☐ Problems with school/work
- ☐ Deterioration in relationships

Perceptual disturbances:
- ☐ Seen, tasted, felt, smelt or heard things that aren't there.

Explain:

Unusual thought content
- ☐ Have special powers or they are someone special
- ☐ Involved somehow in a conspiracy
- ☐ Special meanings from the environment intended for them
- ☐ Being controlled by an external source
- ☐ Thoughts removed / inserted from their head or broadcasted from
- ☐ Other odd beliefs :

Changes in presentation:
- ☐ Strange mannerisms or posturing
- ☐ Easily distractible
- ☐ Disorganised speech
- ☐ Decreasing concentration
- ☐ Speech is hard to follow and is pressured
- ☐ Emotionally withdrawn
- ☐ Heightened emotional tone
- ☐ Restricted range of expressiveness in face, voice and gestures
- ☐ Unable to answer questions because of being perplexed or thought blocked

Any other changes/symptoms?:

When did the above symptoms start, how frequently do they occur and how long do they last?

How does substance use affect symptoms? What impact does the symptoms have on the young person?

Patient Name: _____ **UR Number:** _____

Please include any relevant information in the following areas:

Recent Stresses:

Past trauma:

Family History of Mental Illness:

Substance Use History: *(substance/amount/route/frequency/duration) If ASSIST completed include results.*

Relevant Medical History, Co-morbid mental illness and Current Prescribed Medications if known:

Current Risks: *(Self-harm/suicide/violence/harm to others /homelessness/forensic/ vulnerability)*

Protective Factors: *(Supports/personal strengths/insight/employment/education/ interests)*

Current Needs and Any Existing Plans:

Referrer's Name: _____ **Signature:** _____

Agency: _____ **Date:** ____/____/____

Hume REPS clinician to complete:

Date received: ____/____/____

By whom: _____

Action taken:

"Reference: Yung, Phillips, Simmons, Ward, Thompson, French, McGorry, 2006.
Comprehensive Assessment of at Risk Mental State (CAARMS), Orygen Research Centre, University of Melbourne, Dept of Psychiatry, Parkville, Victoria