

## Service provider referral form

YESS provides care to young people (aged 12-25) with complex mental health needs and associated functional impairment. The program covers the 3 regions listed below, and provides outreach or telehealth services to young people who are unable to attend centre-based appointments. This includes people who need more support than primary care providers such as headspace and ReFrame can offer, and who don't currently meet criteria for tertiary services.

View some [example scenarios](#) and additional eligibility and exclusion criteria for:

- Northern Sydney
- Nepean Blue Mountains
- Western Sydney

**Which region is this young person being referred to?**

Northern Sydney

Nepean Blue Mountains

Western Sydney

**Eligibility criteria:**

- Aged between 12 and 25
- Resides, studies, or works in one of the above PHN regions
- Experiencing, or at risk of experiencing, severe or complex mental health needs and functional impairment
- Consenting and able to engage in the YESS program
- Is medically stable and has a sufficient BMI for psychological work
- Associated complexity of presentation that can't be managed in a typical primary care setting (e.g. GP, private psychologist, school/university counsellor, headspace Centre, ReFrame)
- Those who are relatively new to mental health services, and have not already had significant treatment at a greater intensity than YESS, will be prioritised

**Has the person consented to this referral?**

Yes

No

**If under 16 years of age, has a parent/guardian consented to the referral where applicable?**

Yes

No

If you have answered 'no' to the above question, your referral may not be accepted. Please contact us and we'll talk you through some other options.

### **Important information about your referral:**

- Please note that this form is intended for service providers who are involved in the young person's care. If you are seeking assistance for yourself, or are a family member or friend wanting to refer your loved one, please contact us directly on **1800 YESS PM (1800 9377 76)**
- Please be aware that receipt of the referral does not indicate acceptance to the YESS service. The suitability of the referral will be determined following review by our team. If you have any queries about your referral, please contact us on **1800 YESS PM (1800 9377 76)**, or at **[yess@uniting.org](mailto:yess@uniting.org)**
- Information on this form will assist our team in determining suitability and with the assessment process. Therefore, please complete this form with as much information as possible and provide any supporting clinical documentation available. If the referral does not have adequate information, please be aware that we may need to contact you for further information in order to proceed with the referral.

## Section 1: Young person's details

First name:	Last name:
Date of birth:	Country of birth:
Gender:	Gender pronoun(s):
School name:	Student year:
Country of birth:	Parents' country of birth:
Preferred language:	Language spoken at home:
Interpreter needed:	Interpreter language:
Phone number:	Mobile number:
Email address:	
Home address:	
Suburb:	Postcode:

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## Section 2: Next of kin

Full name:		
Relationship to young person:		
Phone number:	Mobile number:	
Do we have permission to speak to this person?	Yes	No

### Section 3: Health information

**Presenting issues/reasons for referral:**

Please attach any additional notes, discharge summaries, assessment information

**Please list details of primary mental/physical health diagnoses and any other conditions that impact on the young person's wellbeing:**

**Current medications/treatments:**

Please provide details

Antipsychotics	Antidepressants
Anxiolytics	Other
Hypnotics and sedatives	

## Section 4: Current and previous support details

Please note: YESS works routinely with community GPs to coordinate care and at times, offer telepsychiatry appointments. In order for this service to be accessible, please ensure the relevant GP information and associated consent is outlined below.

Is the young person currently, or have they previously been, engaged with any of the following:

Care provider type (Please tick)	Name and contact details	Consent to liaise? (Please tick)
General Practitioner		
School Counsellor		
Private Psychologist		
Psychologist – Assess Plus or Mental Health Care Plan		
Homelessness Service		
Public Mental Health Service		
Psychiatrist		
Child Protection Agency		
Drug and Alcohol Service		
Employment Service		
Other		

## Section 5: Demographics

### Does the young person identify as:

Aboriginal

Aboriginal and Torres Strait Islander

Torres Strait Islander

Neither

### Marital status:

Never married

Married (registered de facto)

Divorced

Widowed

Separated

### Housing status:

Owned home

Private rental

Social housing Aboriginal

Boarding house

Community housing

Public housing

Emergency housing

Homeless

### Living arrangement:

Lives with parent(s)/guardian(s)

Lives with partner

Lives alone

Lives with children

Lives with other family

### Employment status:

Full-time employment

Part-time employment

Casual employment

Studying at school

Unemployed

Studying at university/TAFE

Not in labour force

## Section 5: Demographics continued

### Income source:

<input type="checkbox"/> N/A – not in labour force	<input type="checkbox"/> Compensation payments
<input type="checkbox"/> Paid employment	<input type="checkbox"/> Other
<input type="checkbox"/> Disability Support Pension	<input type="checkbox"/> Nil income
<input type="checkbox"/> Other pension or benefit	

### NDIS involvement:

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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### Does the young person have a Health Care Card?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
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## Section 6: Safety considerations (Please note these are not exclusion criteria)

### Risk of suicide?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Details:

### Non-suicidal self injury?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Details:

### Substance use?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Details:

### Past physical or verbal aggression?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Details:

## Section 6: Safety considerations continued

At risk of homelessness?

Yes

No

Details:

Risk taking/impulsive behaviours?

Yes

No

Details:

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## Section 7: Additional information

Please outline any additional information, history, or anything else you or the young person would like to add:



## Section 8: Referring agent details

Referring agent name:

Service/Organisation:

Designation/Profession:

Telephone:

Fax:

Email:

**Please send the completed referral form to:**

**Email: [yess@uniting.org](mailto:yess@uniting.org)**

**Fax: 02 8820 0737**

The referring agent will be contacted within 3 business days after receipt of the referral to discuss the next steps.