REFERRAL TEMPLATE

This template is designed to support information sharing between services during transitions of care. If your service already has a referral or transfer form, please use that instead.

This template is intended to complement the Toolkit for Supporting Service Transitions in Mental Health Care and can be used alongside the resources provided in the toolkit.

Young person name:		**Pronouns / name preferences:**	
DOB:			
Young person's contact details:			
Next of kin contact details:			
GP:			
Referring clinician/team contact details:			

I confirm that the young person and/or their next of kin is aware of and consenting to this referral. ◯ Yes ◯ No

Brief Introduction - Introduction, Situation, Background, Assessment, Recommendation (ISBAR)
Example: Saskia is a 15-year-old cisgender female who resides with her father and stepmother, and attends John Fawkner College. She has been engaged with headspace Glenroy for six months and was initially referred due to anxiety, low mood and school attendance challenges. Saskia has a history of developmental trauma. Her mother is deceased and she has experienced neglect in her early childhood. She is experiencing depressive symptoms, and recent onset of visual and auditory hallucinations have led to referral to the Youth Access Team, Parkville Youth Mental Health and Wellbeing Service.

Risk
• Suicidal ideation/behaviour (include previous attempts, any planning, timeframe, access to means). • Self-injurious behaviour (frequency, means, severity). • Risk to others (include previous ideation, plan and intent, and past episodes) • Vulnerability risk: neglect, abuse or harm to self, due to poor judgement or impaired insight • Include relevant information about clinical state, stressors and protective factors

Rationale for referral
Example: • The young person has a confirmed or suspected diagnosis that requires ongoing monitoring, support and treatment, including medical intervention that cannot be managed by their GP alone. • For further assessment and formulation. • To manage an acute crisis. • To provide case management when there are complex psychosocial needs. • To complete a specific piece of work, for example, diagnostic clarification and commencement or review of medications, harm minimisation, family, work.

SUPPORTING DOCUMENTS ATTACHED

- ◯ Clinical notes
- ◯ Safety plan

SUMMARY

Working formulation (brief):

Young person's goals/perspective:

Diagnoses/risk summary (including historical risks and dynamic factors):

CARE PLAN

Medication

Current medication/s (name/dose/indication/side effects/monitoring)

Medications trialled, and reasons for discontinuation
(for example, ineffective, side effects, contraindications)

Psychotherapies

Current

Current treating practitioners (for example, psychologist, psychiatrist, allied health)

Adjustments (for example, neurodiversity, trauma-informed care needs, sensory/communication preferences)

CARE PLAN continues to next page

CARE PLAN (CONTINUES)

Physical health

GP details

Relevant past health practitioners (for example, speech pathologist, occupational therapist, paediatrician)

Alcohol and other drugs

Any relevant AOD history

Other supports

Language and cultural considerations

Primary language/interpreter needed:

Aboriginal and/or Torres Strait Islander status:

Legal and consent

Capacity/consent notes, information-sharing agreements, guardianship as relevant

NOTES