NORTH METROPOLITAN HEALTH SERVICE
MENTAL HEALTH

# YCATT REFERRAL FORM

| Surname | | Sex | U.R. No |
|---|---|---|---|
| Forenames | | | D.O.B. |
| Address | | | |
| Ward | Registrar | Consultant | |

*Use Patient I.D. Label when available*

## REFERRER DETAILS

| Name: | Organisation & Position: |
|---|---|
| Contact Number: | Email: |

## YOUNG PERSON DETAILS

| Date of Referral: | UMRN: | Date of Birth: | |
|---|---|---|---|
| Forenames: | Surname: | Preferred Name: | |
| Sex assigned at birth: | Gender Identity: | Sexuality: | Pronouns: |
| Address: | | | |
| Contact Number: | Email: | | |
| Country of birth: | Nationality: | | |
| Aboriginal / Torres Strait Islander: Yes ☐ No ☐ | Cultural & Religious Background: | | |
| Preferred Language: | Interpreter required: Yes ☐ No ☐ | | |

| Question | Response |
|---|---|
| Is the young person between 16–24 years old? | Yes ☐ No ☐ |
| Is the young person willing to engage with YCATT? | Yes ☐ No ☐ Unknown ☐ |
| If under 18, does a parent or guardian consent to the referral? | Yes ☐ No ☐ Unknown ☐ |
| If under 18, has the young person been deemed a Mature Minor? | Yes ☐ No ☐ Unknown ☐ |
| If yes, who assessed young person as mature minor? | ______________________________ |
| If the young person does not want their parent / carer to know about them accessing our services, please let us know. | Doesn't mind ☐ Keep private ☐ Unknown ☐ |
| Has the referral been discussed with the young person? | Yes ☐ No ☐ |
| If not, what is the reason for not discussing? | ______________________________ |
| Is the young person willing to attend weekly individual appointments (home / community / clinic / telehealth)? | Yes ☐ No ☐ |

## EMERGENCY CONTACT DETAILS

| Name: | Relationship to the young person: |
|---|---|
| Contact Number: | Email: |
| Address: | |
| Is the listed emergency contact aware of this referral? Yes ☐ No ☐ | |

## Who should YCATT contact to make an appointment?

Young Person ☐ Emergency Contact ☐ Referrer ☐ Other ☐

## Preferred mode of contact

Call ☐ Text ☐

YCATT REFERRAL FORM

G242
01/23

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**REASON FOR REFERRAL**
*(Presenting issues, impact on functioning, YP's goals, relevant history)*
Health professionals – please attach a mental state assessment / SSCD documentation or discharge summary if available

**CURRENT STATUS**

Provisional / current diagnosis:

Accomodation type / living arrangements:

Work / education:

Substance use (type,amount,frequency):

Legal issues:

**CURRENT MEDICATIONS (DOSE / FREQUENCY / COMPLIANCE)**

**PHYSICAL HEALTH CONCERNS**

**CURRENT RISK / SAFETY ISSUES** (Health professionals, please attach a current risk assessment)

| | Low | Medium | High | Unknown |
|---|---|---|---|---|
| Risk of harm to self | ☐ | ☐ | ☐ | ☐ |
| Risk of harm to others | ☐ | ☐ | ☐ | ☐ |
| Risk of harm to children / pets | ☐ | ☐ | ☐ | ☐ |
| Vulnerability | ☐ | ☐ | ☐ | ☐ |

Please detail historical & current risk / safety issues:

**PAST / PRESENT SERVICE ENGAGEMENT** include any referrals sent to other services.

GP Details:

Other Organisations:

Public / private psychiatric service involvement (past & present):

Mental health treatment plan ☐ NDIS plan ☐

**ANY FURTHER INFORMATION?**