headspace early psychosis

headspace Early Psychosis provides specialised assessment, intervention and case management for young people aged 12-25 in the South East Queensland region who are at risk of, or experiencing, a first episode of psychosis.

The Mobile Assessment and Treatment Team (MATT) are based at Southport and will review this referral and, if suitable, complete an assessment with the young person. MATT will then provide you with feedback and recommendations for this young person.

If the young person is accepted into this program, they will be offered case management by the continuing care team based at either headspace Meadowbrook or headspace Southport depending on where they live.

Thank you for this this referral and please do not hesitate to contact the **Mobile Assessment and Treatment Team** on **0423 614 781** if you have any further questions or feedback.

Young Person Being Referred to headspace Early Psychosis

First Name:		Last Name:			
Date of Birth:		Gender:		Pronouns:	
Phone contact:					
Email:					
Address:					
Emergency Contact:					

Consent for Referral

headspace Early Psychosis is a voluntary service, as such consent from the young person is required for this referral to be processed.

I give consent for this referral to be made to headspace Early Psychosis service across Southport and Meadowbrook

and

I give permission for headspace Early Psychosis staff to obtain relevant information from government and non-government agencies, from doctors and other health professionals relevant to my care whilst a client of headspace Early Psychosis

Young person Name:			
Signed ☐ Verbal ☐	Sign here:	Date:	

If the person being referred is under the age of 18, consent from their legal guardian is also required.

Parent/Legal Guardian Name:			
Signed ☐ Verbal ☐	Sign here:	Date:	

headspace Meadowbrook
260 Loganlea Rd
Meadowbrook, QLD
Ph: 07 3804 4200

headspace Southport
Level 1, H20 Broadwater 1, 2 Nind St Southport
Ph: 07 5509 5900

Does the young person have any current mental health diagnoses/uses medication: Yes ☐ No ☐
If yes, please specify:

Does the young person have any current physical health diagnoses/uses medication: Yes ☐ No ☐
If yes, please specify:

Young Person Symptomology

Noticeable decline or drop in functioning (moderate difficulty in social, occupational or school functioning - not functioning at any age appropriate level)	Yes ☐ No ☐
1st degree relative with psychosis, schizophrenia or BPAD (parents, brother or sister)	Yes ☐ No ☐
Attending school/university/TAFE or engaged in the workforce	Yes ☐ No ☐
Substance use	Yes ☐ No ☐
Risk to self	Yes ☐ No ☐
Risk to others	Yes ☐ No ☐
Currently prescribed medication	Yes ☐ No ☐
Hallucinations or perceptual disturbances:	Yes ☐ No ☐
Delusional beliefs (ideas of reference, paranoia, suspiciousness, grandiosity)	Yes ☐ No ☐
Blunted affect	Yes ☐ No ☐
Odd or unusual behaviour	Yes ☐ No ☐
Decrease in motivation/energy/lack of interest in activities	Yes ☐ No ☐
Social withdrawal/isolation	Yes ☐ No ☐
Cognitive decline (concentration, memory, planning)	Yes ☐ No ☐
Change in appetite and/or sleep	Yes ☐ No ☐

Note to referrer

To inform a comprehensive assessment and care for this young person, headspace Early Psychosis *kindly requests further information attached to this referral if you have ticked 'Yes' to any of the above*

If you are referring from a hospital or health service, please include the following information:

- Most recent consumer assessment and rapid triage form
- Latest case review notes and care plan
- A copy of all medical review notes
- A copy of all blood tests, imaging or any other investigations which have been completed during assessment, admissions or case management period

Referrer Details

Contact Name:			
Organisation Name:			
Position:			
Email:			
Phone:		Fax:	
Signed:			

Please return the completed form and the supporting documents to:
Email: earlypsychosis@headspacesouthport.org.au
Ph: 0423 614 781 Fax: 07 5527 1251