**Youth Hospital in the Home (Y-HITH)**

**Referral Form (2 pages)**

**Phone 6159 6436 or 0427 160 426**

**Fax to: 6159 6388 or**

**­ Email to** [**youth.hith@health.wa.gov.au**](mailto:youth.hith@health.wa.gov.au)

|  |  |
| --- | --- |
| **Referrer:** | |
| **Organisation:** | **Date/Time referred:** |
| **Name:** | **Designation:** |
| **Contact number:** | |

|  |  |  |
| --- | --- | --- |
| **Referred Patient: UMRN:** | | |
| **Forenames:|** | **Surname: DOB:** | |
| **Address:** | | |
| **Contact number:** | **Aboriginal/Torres Strait Islander:** | |
| **Sex assigned at birth Male ☐ Female ☐** | **Gender identity:** | |
| **Any language, cultural or communication requirements ☐ Interpreter required ☐ Language spoken** | | |
| **Known hazards/alerts [e.g. animals, aggression] –** | | |
| **Next of Kin/Guardian Parent ☐ Legal Guardian ☐ Partner ☐ Next of Kin ☐ Nominated Person ☐** | | |
| **Forenames:** | | **Surname:** |
| **Address:** | | |
| **Contact number:** | | |
| **Any language, cultural or communication requirements ☐ Interpreter required ☐ Language spoken** | | |

**Affix Client identification label below:**

**Suitability Checklist:**

**Between 16 and 24 years old Yes ☐ No ☐**

**Willing to participate with Y-HITH treatment Yes ☐ No ☐**

**Has stable accommodation within North Metropolitan Catchment Area Yes ☐ No ☐**

**(If under 18) Parent or guardian consenting to the referral Yes ☐ No ☐**

**(If under 18) Has a support person living at home for the length of Yes ☐ No ☐**

**admission unless considered mature minor**

|  |
| --- |
| **Current Medications (including allergies):**    **Presenting problems:**  **Please attach the current clinical notes including mental state examination and risk assessment to the form:**  **What are the goals of the referral?**  **Please indicate any new services identified for the client and if the referral has been sent:**  **Key investigations and results:** |

|  |
| --- |
| **Admitting Psychiatrist: Consultant Psychiatrist at YHiTH**  **Please call YHiTH on 9347 6436 or 0427160 426 to discuss the referral and current bed availability**  **Discussed with:**  **Time/Date discussed:** |

|  |
| --- |
| Please note:This referral does not guarantee the referred person admittance to Y-HITH. The referrer will be contacted by a Y-HITH staff member to arrange a suitability assessment. Once assessment is completed the referrer will be contacted regarding an outcome. |