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 ☐

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 ☐

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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?