emerge
Referral Form

This referral form may be completed by community members and health professionals. Please ensure you read the **Referral Guidelines** prior to completing this form.

GPs should complete a Mental Health Treatment Plan and fax to the Central Referral Unit (1300 580 249) for purposes of referral.

Note: Acute risk young people may not be appropriate for this service. Emergency mental health services should be contacted by calling 13 14 65

All details must be completed or the referral will not be accepted.

To refer a young person to Sonder Edinburgh North - Fax the completed referral form to Sonder Edinburgh North on (08) 8252 9433 and follow-up with a phone call on (08) 8209 0700 to ensure receipt of referral.

To refer a young person to Sonder Onkaparinga- Fax the completed referral form to Sonder Onkaparinga on (08) 8186 8699 and follow-up with a phone call on (08) 8186 8600 to ensure receipt of referral.

Date of Referral:	

Young person details

Name:		**Gender Identity:**	
DOB:		**Pronouns**	
Address:		**Phone:**	
Parent or Guardian name:		**Phone:**	
Does the client identify as an Aboriginal and/or Torres Strait Islander or of a Culturally and Linguistically Diverse background?		Yes ❒	No ❒

Referrer details

Name:		**Phone:**	
Email:		**Fax:**	
Organisation and Address:			

Reasons for referral to **emerge -** include main concern, onset, duration, impact of concern on young person, current and previous treatment and/or any other useful background information:

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Difficulties/Behaviours		Comments		
Anxiety (high level symptoms of anxiety and significant impact on functioning)	Yes ❒ No ❒	Examples - Feeling nervous, anxious, or on edge, panic, fear of social situations, not being able to stop or control worrying, breathlessness, heart-racing, difficulty relaxing, restless, easily annoyed or irritable, shaky, difficulty concentrating		
Depression (high level depressive symptoms and significant impact on functioning)	Yes ❒ No ❒	Examples - Feelings of hopelessness, sadness, feeling empty inside, crying, sleep disturbance (increased or decreased), decreased motivation/interest or pleasure, difficulty concentrating		
Borderline Personality Disorder (formal diagnosis, emerging personality disorder or significant traits of this disorder + significant impact on functioning)	Yes ❒ No ❒	Examples – mood instability, difficulties in managing emotions, self-harming behaviour, suicidal ideation/previous attempts, difficulties with identity, unstable self-image or sense of self, chronic feelings of emptiness, difficulties/conflict in relationships with others, impulsivity, anger/difficulty controlling anger		
Bipolar Disorder (formal diagnosis or significant traits of this disorder + significant impact on functioning)	Yes ❒ No ❒	Examples - periods of high, or elevated moods, feeling 'high', extremely energetic, talking more, making decisions in a flash, 'on the go', feeling less need for sleep, irritability, restless, delusions or hallucinations, 'abnormally upbeat, jumpy or wired'. Periods of depression may also be present		
Trauma (high level symptoms and significant impact on functioning)	Yes ❒ No ❒	Examples – exposure to a traumatic event or events, unwanted memories of the stressful experience/s, nightmares, flashbacks, avoiding thinking about the traumatic event/s, changes in thoughts and mood, feeling 'jumpy', irritability, anger, reckless behaviour, getting startled easily, overly alert to danger (hyper vigilance)		
Psychosis (high level symptoms and significant impact on functioning)	Yes ❒ No ❒	Examples – delusions, hallucinations, disordered thinking/speech, disordered behaviour		
Eating Disorder (must be < 3 years in duration)	Yes ❒ No ❒	**Restricting food intake**	Yes ❒	No ❒
		Binge eating	Yes ❒	No ❒
		Vomiting	Yes ❒	No ❒
		Laxative use	Yes ❒	No ❒
		Driven exercise	Yes ❒	No ❒
		Other (e.g. diuretics)	Yes ❒	No ❒
		Duration of behaviours:		
		Weight: **Height:** **BMI:** **Weight changes in last 6 months:**		

Current suicide risk

Health Professionals - please attach current risk assessment, mental state examination, summary of care episode and service requested

Educational/Community Services - please include safety assessment and current summary of care

Tick each of the following options:

Is the young person currently having thoughts of suicide that you are aware of? ❒ Yes ❒ No

Does the young person have a current plan to end their life that you are aware of? ❒ Yes ❒ No

If you have answered YES to either of the above questions please contact us immediately on (08) 8209 0700 (emerge North) or (08) 8186 8600 (emerge South) to discuss the referral suitability with the Triage worker.

If you are concerned about this person's risk to themselves or others, please indicate how:

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Other information

Is the young person currently engaged with any other services? (if yes, please specify)			
Has the young person accessed other mental health services in the past? (if yes, please specify)			
Has the young person been asked to attend a GP to get a Mental Health Care plan? (strongly recommended)		❒ Yes ❒ No	
Does the young person have an existing GP?		❒ Yes ❒ No **(If yes, please fill in the details below)**	
GP Name:		**Phone:**	
GP Practice location/address		**Fax:**	

Consent for Referral	
The young person is aware of the referral and consents to this, and to the referrer providing/receiving written and verbal information to/from Sonder for the purpose of facilitating this referral.	❒ Yes ❒ No

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