| Date:       *(yy/mm/dd)* | Name of Individual: Last Name, First Name  | CID:       |
| --- | --- | --- |
| **Inclusion Criteria** (*Please check*)[ ]  Person is between the ages of 14 and 35, resides in Waterloo Region or Wellington County.[ ]  Person has experienced recent symptoms of a first episode of psychosis of less than one year.[ ]  Have received either no treatment for psychosis or 6 months or less treatment of psychosis.[ ]  Symptoms of psychosis is the primary issue or concern.[ ]  Person is aware the referral is being made for them. **Relevant Documents (please send along with referral)****[ ]** Psychiatric Consult Notes**[ ]** Assessment/Consultation Notes**[ ]** Psychological Reports**[ ]** Discharge Summary Profile**[ ]** MAR Sheet (medication records)**[ ]** Previous Hospital Psychiatry Notes/Discharge Summary’s. **NOTE: FAILURE TO INCLUDE RELEVANT INFORMATION AND DOCUMENTS WITH THIS REFERRAL WILL DELAY THE REFERRAL PROCESS****Personal Information**Name:       Gender:      DOB:      (yy/mm/dd)Age:       Address:      Phone:       Currently resides with [ ]  Alone [ ]  Family [ ]  OtherHealth Card Number:       Version Code:      Ethnicity:      Preferred language:      Interpreter required: [ ]  Yes [ ]  No**Emergency Contact**Name:       Relationship:      Phone:      **Family Doctor**Name:       City:       Phone:      Fax:      **Family Contacts**Name:       Relationship:      Phone number:      Name:      Relationship:      Phone number:      **Referral Source Information**Name:       Organization:      Address:      Phone:       Fax:      Billing #:       (Required if referral is coming from hospital or primary care provider)**Symptoms**Please check all that apply and give specific examples[ ]  Hallucinations: Click or tap here to enter text.[ ]  Observed responding to internal stimuli: Click or tap here to enter text.[ ]  Delusions: Click or tap here to enter text.[ ]  Confused thinking: Click or tap here to enter text.[ ]  Mood changes: Click or tap here to enter text.[ ]  Cognitive changes: Click or tap here to enter text.[ ]  Behaviour changes: Click or tap here to enter text.[ ]  Paranoia: Click or tap here to enter text.**Mental Health History**Please include any previous psychiatric diagnosis/treatments/hospitalizationsClick or tap here to enter text.**Medication**Leave blank if MAR sheet has been attachedClick or tap here to enter text.Has this person been tried on anti-psychotic medication?[ ]  Yes [ ]  NoIf yes, when and where? Click or tap here to enter text.**Family History**Click or tap here to enter text.**Substance Use History**Please list substance, frequency and amounts if known as well as date of last use.Click or tap here to enter text.Does this person see their substance use as an issue in their life? [ ]  Yes [ ]  No**Medical History**Click or tap here to enter text.Diagnosed developmental disability [ ]  Yes [ ]  NoHas this person experienced suicidal ideation [ ]  Yes [ ]  NoHave they ever attempted to end their life? [ ]  Yes [ ]  NoIf yes, when? Click or tap here to enter text.**Risk Assessment**Danger to self:      Danger to others:      Danger from others:      Other:      Who should be contacted with appointment information?      Can a message be left on voicemail? [ ]  Yes [ ]  NoIf this person is currently in hospital, what is the approximate discharge date?      **Please consider including us in any discharge planning meetings.**If you have any referral processing questions and/or concerns, please contact:1st Step, Intake ClinicianCanadian Mental Health Association Waterloo Wellington80 Waterloo Ave.Guelph, ONN1H 0A1Ph: 1-844-264-2993 x2040Fax: 519-821-6139 |
|  |
| CC: Client Family:       Date:       Referral Source/GP:       Date:       Other:       Date:        |