| **Referral Date**:       *(yy/mm/dd)* | | | | | | | | | | | **Name of Individual**: Last Name, First Name | | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **\*FAX COMPLETED FORM TO EPI INTAKE @ 519-821-6139** | | | | | | | | | | | | | | | | | | | | | | | | |
| **\*NOTE: FAILURE TO INCLUDE RELEVANT INFORMATION AND DOCUMENTS WITH THIS REFERRAL WILL DELAY THE REFERRAL PROCESS** | | | | | | | | | | | | | | | | | | | | | | | | |
| **CLIENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | | |  | | | | **Gender:** | |  | | | | | | | | **Date of Birth:** | | | **(yy/mm/dd)** | | | |
| **Address:** | | | |  | | | | | | | | | | | | | | | | | | | | |
| **Personal Cell:** | | | |  | | | | **Home Phone:** | |  | | | | | | | | **Email:** | | |  | | | |
| **Voicemail Okay?** | | | | | | | | **Voicemail Okay?** | | | | | | | | | | | | | | | | |
| **Currently resides with:** | | | | | **Alone** | | | | | | **Family** | | | | | | | **Other** | | | | | |  |
| **Health Card Number:** | | | | |  | | | | | | **Version Code:** | | | | | |  | | | | | | | |
| **Preferred Language:** | | | | |  | | | | **Interpreter Required:** | | | | | | | | **Yes** | | | | | **No** | | |
| **Cultural Considerations:** | | | | |  | | | | | | | | | | | | | | | | | | | |
| Patient Label  (Hospital Only) | | | | | | | | | | | | | | | | | | | | | | | | |
| **EMERGENY CONTACT** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | |  | | | | | | | | | **Relationship:** | | | |  | | | | | | | | |
| **Phone:** | | |  | | | | | | | | | | | | | | | | | | | | | |
| **Individual provides consent for CMHA WW to contact this person?** | | | | | | | | | | | | | | | | | **Yes** | | | | | **No** | | |
| **PRIMARY CARE PROVIDER (GP/NP)** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | |  | | | | | | | | | **City:** | | | |  | | | | | | | | |
| **Phone:** | | |  | | | | | | | | | **Fax:** | | | |  | | | | | | | | |
| **FAMILY CONTACTS** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | |  | | | | | | | | | **Relationship:** | | | |  | | | | | | | | |
| **Phone:** | | |  | | | | | | | | | | | | | | | | | | | | | |
| **REFERRAL SOURCE INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | |  | | | | | | | | | **Organization:** | | | |  | | | | | | | | |
| **Address:** | | |  | | | | | | | | | | **Phone:** | | |  | | | | **Fax:** | | |  | |
| **Billing # *(Required if referral is coming from hospital or primary care provider):*** | | | | | | | | | | | | | | | | | | | |  | | | | |
| **Who should be contacted with appointment information?** | | | | | | | | | | | | | | | | | | | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| **INCLUSION CRITERIA (*Please check all that apply)*** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 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 for less than one year | | | | | | | | | | | | | | | | | | | | | | | |
|  | Has received six months or less treatment for psychosis | | | | | | | | | | | | | | | | | | | | | | | |
|  | Symptoms of psychosis is the primary issue or concern | | | | | | | | | | | | | | | | | | | | | | | |
|  | Person is aware the referral is being made for them | | | | | | | | | | | | | | | | | | | | | | | |
| **RELEVANT DOCUMENTS *(Please attach to referral)*** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Psychiatric Consult Notes | | | | | | | | | | | | | | | | | | | | | | | |
|  | Assessment/Consultation Notes | | | | | | | | | | | | | | | | | | | | | | | |
|  | Psychological Reports | | | | | | | | | | | | | | | | | | | | | | | |
|  | Discharge Summary Profile | | | | | | | | | | | | | | | | | | | | | | | |
|  | MAR Sheet (medication records) | | | | | | | | | | | | | | | | | | | | | | | |
|  | Previous Hospital Psychiatry Notes/Discharge Summaries | | | | | | | | | | | | | | | | | | | | | | | |
| **SYMPTOMS** ***(Please check all that apply and give specific examples):*** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Hallucinations (Auditory/Visual/Other):** | | | | | | | | | | | | | | | | | | | | | | | |
|  | Enter text here | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Observed Responding to Internal Stimuli (Speaking aloud/thought blocking):** | | | | | | | | | | | | | | | | | | | | | | | |
|  | Enter text here | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Delusions**: | | | | | | | | | | | | | | | | | | | | | | | |
|  | Enter text here | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Confused Thinking/Cognitive Changes:** | | | | | | | | | | | | | | | | | | | | | | | |
|  | Enter text here | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Mood Changes/Changes in Affect:** | | | | | | | | | | | | | | | | | | | | | | | |
|  | Enter text here | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Functional Changes (School/Work/Activities of Daily Living Performance):** | | | | | | | | | | | | | | | | | | | | | | | |
|  | Enter text here | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Behaviour Changes (Bizarre/Disorganized):** | | | | | | | | | | | | | | | | | | | | | | | |
|  | Enter text here | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Paranoia**: | | | | | | | | | | | | | | | | | | | | | | | |
|  | Enter text here | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | |
| **MENTAL HEALTH HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please include current and previous diagnostic impression, diagnoses, and treatment:** | | | | | | | | | | | | | | Enter text here | | | | | | | | | | |
| **Has there been any previous hospitalizations for mental health reason?** | | | | | | | | | | | | | | **Yes** | | | | **No** | | | | | | |
| **If yes, when, and where?** | | | | | | | | | | | | | | Enter text here | | | | | | | | | | |
| **MEDICATION *(\*Leave blank if MAR sheet has been attached)*** | | | | | | | | | | | | | | | | | | | | | | | | |
| Enter text here | | | | | | | | | | | | | | | | | | | | | | | | |
| **Has this person been tried on anti-psychotic medication?** | | | | | | | | | | | | | | **Yes** | | | | **No** | | | | | | |
| **If yes, when, and where?** | | | | | | | | | | | | | | Enter text here | | | | | | | | | | |
| **FAMILY HISTORY *(Mental Health, addictions, major medical diagnosis)*** | | | | | | | | | | | | | | | | | | | | | | | | |
| Enter text here | | | | | | | | | | | | | | | | | | | | | | | | |
| **SUBSTANCE USE HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please list substance, frequency, and amounts (if known):** Enter text here | | | | | | | | | | | | | | | | | | | | | | | | |
| **Does this person see their substance use as an issue in their life?** | | | | | | | | | | | | | | **Yes** | | | | **No** | | | | | | |
| **MEDICAL HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | |
| Enter text here | | | | | | | | | | | | | | | | | | | | | | | | |
| **Diagnosed developmental disability?** | | | | | | | | | | | | | | **Yes** | | | | **No** | | | | | | |
| **If yes please include:** | | | | | | | | | | | | | | **Yes** | | | | **No** | | | | | | |
| **RISK ASSESSMENT** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Danger to self?** | | | | | | | | | | | | | | **Yes** | | | | **No** | | | | | | |
| **Has this person experienced suicidal ideation?** | | | | | | | | | | | | | | **Currently** | | | | **Historically** | | | | | | |
| **Have they ever attempted to end their life?** | | | | | | | | | | | | | | **Yes** | | | | **No** | | | | | | |
| **If yes, please provide details:** | | | | | | | | | | | | | | Enter text here | | | | | | | | | | |
| **Danger to others (Example: Homicidal/access to weapons):** | | | | | | | | | | | | | | Enter text here | | | | | | | | | | |
| **Danger from others (Example: Gang involvement, domestical violence):** | | | | | | | | | | | | | | Enter text here | | | | | | | | | | |
| **Other risks (Example: Sexual deviance, communicable disease):** | | | | | | | | | | | | | | Enter text here | | | | | | | | | | |
| **Does this person have any active legal charges?** | | | | | | | | | | | | | | **Yes** | | | | **No** | | | | | | |
| **If yes, provide details:** | | | | | | | | | | | | | | Enter text here | | | | | | | | | | |
| **Does this person have capacity of decision-making regarding treatment?** | | | | | | | | | | | | | | **Yes** | | | | **No** | | | | | | |
| **If no, who is the Substitute Decision Maker?** | | | | | | | | | | | | | | Enter text here | | | | | | | | | | |
| **Does this person have a CTO?** | | | | | | | **Yes** | | | | | | | **No** | | | **Considering** | | | | | | | |
| **If this person is currently in the hospital, what is the approximate discharge date?** | | | | | | | | | | | | | | | | | | | | Enter text here | | | | |
|  | | | | | | | | | | | | | | | | | | | |  | | | | |
| **We are invested in discharge planning, please invite us to participate.** | | | | | | | | | | | | | | | | | | | | | | | | |
| **If you have any referral processing questions and/or concerns, please contact:**  1st Step, Intake Clinician  Canadian Mental Health Association Waterloo Wellington  80 Waterloo Ave.  Guelph, ON  N1H 0A1  Ph: 1-844-264-2993 x2040  Fax: 519-821-6139 | | | | | | | | | | | | | | | | | | | | | | | | |
| **CC:** | | **Primary Care Provider:** | | | |  | | | | | | | | | **Date:** | | | |  | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | |