| **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 ClinicianCanadian Mental Health Association Waterloo Wellington80 Waterloo Ave.Guelph, ONN1H 0A1Ph: 1-844-264-2993 x2040Fax: 519-821-6139 |
| **CC:** | **Primary Care Provider:**  |       | **Date:** |       |
|  |  |