EARLY PSYCHOSIS INTERVENTION (EPI) PROGRAM

CONFIDENTIAL REFERRAL FORM

Inclusion Criteria:

- ☐ Applicant is 14-34 years of age
- ☐ The applicant is experiencing a *first episode of psychosis* with symptom duration of one year or less
- ☐ Applicant resides within Durham Region
- ☐ Applicant is agreeable to referral and willing to engage in EPI services

Exclusion Criteria:

- ☐ Developmental delay or intellectual deficits that would impede participation in a manualized treatment protocol
- ☐ Substance dependence that would impede the treatment process
- ☐ Duration of psychosis symptoms greater than one year (with or without treatment)

LAST NAME	FIRST NAME	SEX	DOB (month/day/year):

ADDRESS (STREET)	CITY/TOWN	POSTAL CODE

PREFERRED TELEPHONE NUMBER:	NEXT OF KIN:

HEALTH CARD NUMBER	LEGAL GUARDIAN (only necessary if child is under 16 years of age):

CAN A VOICE MAIL MESSAGE BE LEFT AT THE ABOVE NUMBER(S)?	IS THE APPLICANT AWARE & AGREEABLE TO THIS REFERRAL?
☐ YES ☐ NO	☐ YES ☐ NO

With permission from the applicant, is there an alternative contact in the event we are unable to reach the applicant?

Name:

Telephone Number:

Relationship to the Applicant:

REASON FOR REFERRAL:

_____

_____

_____

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Durham Amaze – Early Psychosis Intervention (EPI)
The Whitby Mall – 1615 Dundas St. E., 2nd Floor, Suite W214, Whitby, ON, L1N 2L1
Telephone: (905) 721-4747 ext. 8 Fax: (905) 434-7716

DOES THE APPLICANT HAVE A FAMILY PHYSICIAN? ☐ YES ☐ NO	IF ANSWERED YES: Family Physician Name: Family Physician Telephone:
REFERRAL SOURCE NAME:	**REFERRAL SOURCE TELEPHONE NUMBER:**
REFERRAL SOURCE FAX NUMBER:	
REFERRAL TYPE: ☐ Self ☐ Family or Friend ☐ Physician ☐ Service Provider ☐ Other (please specify):	

Psychotic Symptoms (please check applicable symptoms):

☐ Hallucinations	☐ Paranoia	☐ Thought Disorder
☐ Disorganized Behaviours	☐ Decreased Motivation	☐ Functional Decline
☐ Sleep Disturbances	☐ Mood Changes	☐ Social Withdrawal
☐ Suicidal Ideations/Self Harm	☐ Aggressive Behaviour	☐ Bizarre Behaviour
Other Symptoms Observed:		

Substance Use (please check all that apply):

	Current or Past	Frequency & Amount
☐ Alcohol		
☐ Tobacco/Nicotine		
☐ Cannabis		
☐ Stimulants		
☐ Hallucinogens		
☐ Opiate Use		
☐ Other:		

Current Medications (psychiatric and non-psychiatric):

Medication	Dose & Frequency	Comments (i.e., side effects)

Past Medications (psychiatric and non-psychiatric):

Medication	Dose & Duration	Response (i.e., adverse effects)

Psychiatric Hospitalization History:

Hospital	Admission & Discharge Date	Reason(s) For admission

NOTE: *If the applicant is currently admitted in hospital, what is the approximate discharge date?*

Medical History:

Allergies:

Family History of Mental Illness:

Illness (diagnosed or undiagnosed)	Maternal or Paternal	Family Member

Legal History/Involvement:

Please list any individuals or agencies that are currently providing community services to the applicant (i.e., support/case management):

Agency /Service Provider	Contact Person	Telephone Number	Role

The purpose of this referral form is to determine whether or not someone is eligible for services at Durham Amaze's EPI Program.

Please acknowledge the following statements prior to sending a referral to Durham Amaze EPI:

- ☐ All relevant documentation is included with this referral (e.g., consultation notes, psychiatric assessments, hospital discharge summaries, neuropsychological testing, educational assessments).
- ☐ Durham Amaze does not provide crisis support during the assessment process or wait list period.
- ☐ Durham Amaze does not serve as a consultation service for diagnostic clarification.
- ☐ The referral source will remain involved in care or make alternative care arrangements until the applicant is assessed and program eligibility is determined.

Once the <u>completed</u> referral is received, our Intake Coordinator will contact the applicant to perform an intake assessment to determine the applicant's eligibility and suitability for our program. If the applicant is not eligible for services, the referral source will be notified. Thank you for your referral.

DATE OF REFERRAL (day/month/year):	REFERRAL SOURCE SIGNATURE:

<u>Durham Amaze Contact Information:</u>

Reception (general EPI service inquiries): (905) 721-4747 ext. 8

Confidential Fax Number: (905) 434-7716

INCOMPLETE REFERRALS WILL BE SENT BACK TO THE REFERRAL SOURCE