



**Lakeridge  
Health**

**LAKERIDGE HEALTH – DURHAM  
EARLY PSYCHOSIS INTERVENTION  
CONFIDENTIAL REFERRAL FORM**

(ONLY FOR INDIVIDUALS AGES 14–34)

**\*\*\* REFERRALS WILL NOT BE ACCEPTED FOR CLIENTS  
WITH MORE THAN ONE (1) YEAR OF UNTREATED PSYCHOSIS\*\*\***



LAST NAME		FIRST NAME		SEX	DATE OF BIRTH	Day	Month	Year
ADDRESS (STREET)				CITY/TOWN			POSTAL CODE	
HOME TELEPHONE				WORK TELEPHONE				
HEALTH CARD NUMBER				RELATIONSHIP TO PATIENT				
LEGAL GUARDIAN (only necessary if child is under 16 years of age)								
<b>REASON FOR REFERRAL:</b> _____ _____ _____ _____ _____								
FAMILY PHYSICIAN (Please print)					PHONE NO:		BILLING NO:	
REFERRING PHYSICIAN (If different from above) (Please print)					PHONE NO:		BILLING NO:	
DATE:				SIGNATURE:				

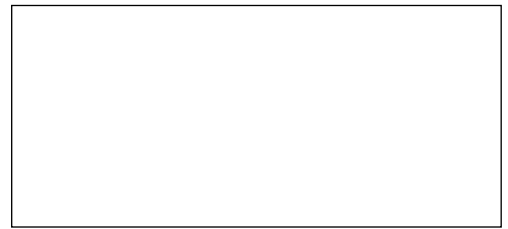
1. Current presentation (please check the appropriate boxes regarding signs/symptoms/behaviors):

- Hallucination ↑   
  Delusions   
  Thought Disorder   
  Disorganized behaviors  
 Decreased motivation   
  Decline in Functioning   
  Sleep Disturbance   
  Alogia  
 Shift in Eating Patterns   
  Social Withdrawal   
  Anhedonia   
  Suspiciousness  
 Suicidal Ideation   
  Violence/Aggressive Behavior   
  Drug use (past/current)

Others: \_\_\_\_\_

Durham **amaze** – Durham Early Psychosis Intervention  
 The Whitby Mall, 1615 Dundas Street, Lang Tower, 2nd Floor, Suite W214, Whitby, Ontario L1N 2L1  
 Intake: Telephone – (905)–576–8711 ext 6029 Fax – (905)–434–7716





2. Current Medication:

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3. Past psychiatric history and treatment:  
(Specify all medications tried, with dose and duration of trial)

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4. Psychiatric services used:  
List all known psychiatric hospitalizations in the past:

Hospital	Admission & Discharge date	Reason(s) for admission

List all known crisis or emergency contacts over the past year:

Location	Date	Reason(s) for seeking crisis/emergency intervention

5. Family History of Mental Illness (please specify family member and illness):

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6. Relevant Health History:

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7. Legal History/involvement:

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8. Please list any individual or agencies that are currently providing community services to this client (support/case management). Please identify primary worker with a check mark

Name of individual/Agency	Contact Person	Telephone Number	Service Provider

9. Please indicate if the client is aware of this referral being made?  Yes  No

Use this space if you wish to make additional comments.

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**\*\*\*Please provide any consult notes/drug screens or relevant test results to assist in this referral process.\*\*\***

**FOR OFFICE USE ONLY:**

**FOR OFFICE USE ONLY:** Unique #: \_\_\_\_\_ Date Received: \_\_\_\_\_

Initials: \_\_\_\_\_

Date Screened: \_\_\_\_\_ Initials: \_\_\_\_\_ Assigned to: \_\_\_\_\_

Date/Time: \_\_\_\_\_ Notified By: \_\_\_\_\_ On: \_\_\_\_\_

