Lakeridge Health

DURHAM amaze

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)

REASON FOR REFERRAL:

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

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2. Current Medication:

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

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):

6. Relevant Health History:

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7. Legal History/involvement:

_____

_____

_____

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.

_____

_____

_____

*****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: _____

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