205 8th St.
Hoquiam, WA 98550
Phone: 360-532-8629 Fax: 360-538-9293

REFERRAL FORM
New Journeys First Episode Psychosis (FEP) Program

Referral Organization Information:

Referral Date:	Is the youth aware of the referral? ☐ Yes ☐ No
Referred by: Agency/Relationship to client:	Referent Phone #:
What kind of insurance does the youth/young adult have: ☐ Medicaid ☐ Private Insurance ☐No Insurance	

Client Information:

Name of referred individual: DOB/Age: Gender: Resident of Grays Harbor County ☐ Yes ☐ No	Address: Phone:
Name/phone # of parent/primary care giver if applicable:	
Race: Hispanic origin? ☐ Yes ☐ No Bi-Racial/other race (specify):	Highest grade level completed: School:
Does the individual being referred have an existing mental health diagnosis? ☐ Yes ☐ No Please list any known diagnoses:	
Is the individual already receiving services for mental health? ☐ Yes☐ No If yes, where?	
Reason for Referral:	

Please review the following items and check all that apply:

☐ The individuals speech doesn't make sense
☐ The individual has behaviors, speech, or beliefs are uncharacteristic and/or bizarre
☐ The individual reports hearing voices or sounds that others do not
☐ The individual feels that other people are putting thoughts in their head, stealing their thoughts
☐ The individual believes others can read their mind (or vice versa)
☐ The individual believes that they do not exist or that their surroundings are not real
☐ The individual has experienced a significant decline overall functioning
☐ The individual has experienced significant changes in sleep (sleeping less or sleeping too much)
☐ The individual has been experiencing increased fear or anxiety for no apparent reason
☐ There is a family history of major psychotic disorder
☐ The individual has an existing diagnosis of Autism Spectrum Disorder
☐ The individual has a history of Drug/marijuana/alcohol use (list substances used below):

Is the individual experiencing any other symptoms not listed? ☐ Yes ☐ No Please explain:
When did you first notice these changes in the individual being referred?
Safety Concerns?
Has the individual ever been prescribed antipsychotic medication? ☐ Yes ☐ No What medications are currently being prescribed? Who is prescribing the medications?

PROGRAM ELIGIBILITY REQUIREMENTS

1) Age: 15-40

2) Resident of Grays Harbor County

3) Psychotic Sxs: Present between 1week and 2 years

4) Primary Dx: Schizophrenia, Schizoaffective, Schizophreniform, Brief Psychotic, Delusional, or Other Specified Psychotic Disorder

****Exclusion Criteria: Psychosis is due primarily to 1) substance intoxication and/or withdrawal, 2) a medical condition, or 3) a current dx of Mood Disorder, Pervasive Developmental Disorder, and/or Autism Spectrum Disorder; Documented IQ <70.***

***FAX FORM TO: Mark Grannemann, New Journeys Clinical Supervisor at 360-538-9293**

(*Questions? Contact Mark at 360-532-8629 or* mgrannemann@bhr.org)

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