**\*\*\*REFERRAL FORM\*\*\***

**New Journeys First Episode Psychosis (FEP) Program**

**Referral Organization Information:**

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| --- | --- |
| Referral Date: Click here to enter a date. | Is the youth aware of the referral? [ ]  Yes [ ]  No |
| Referred by: Click here to enter text.Agency/Relationship to client: Click here to enter text. | Referent Phone #:Click here to enter text. |
| What kind of insurance does the youth/young adult have:[ ]  Medicaid [ ]  Private Insurance Click here to enter text. [ ] No Insurance |

**Client Information:**

|  |  |
| --- | --- |
| Name of referred individual: Click here to enter text.DOB/Age: Click here to enter text.Gender: Choose an item.Resident of [ ]  Thurston [ ]  Mason or [ ]  Grays Harbor County  | Address:Click here to enter text. |
| Phone: Click here to enter text. |
| Name/phone # of parent/primary care giver if applicable: Click here to enter text. |

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| --- | --- |
| Race: Choose an item.Hispanic origin? [ ]  Yes [ ]  NoBi-Racial/other race (specify): Click here to enter text. | Highest grade level completed:Choose an item.School: Click here to enter text. |
| Does the individual being referred have an existing mental health diagnosis? [ ]  Yes [ ]  NoPlease list any known diagnoses: Click here to enter text.  |
| Is the individual already receiving services for mental health? [ ]  Yes[ ]  NoIf yes, where? Click here to enter text. |
| Reason for Referral: Click here to enter text. |
| 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):Click here to enter text. |

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| --- |
| Is the individual experiencing any other symptoms not listed?[ ]  Yes [ ]  NoPlease explain: Click here to enter text. |
| When did you first notice these changes in the individual being referred? Click here to enter text. |
| Safety Concerns? Click here to enter text. |
| Has the individual ever been prescribed antipsychotic medication? [ ]  Yes [ ]  No What medications are currently being prescribed? Click here to enter text.Who is prescribing the medications? Click here to enter text. |

**PROGRAM ELIGIBILITY REQUIREMENTS**

***1) Age: 15-40***

***2) Resident of Thurston, Mason, or 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: Katherine LaBranche, New Journeys Program Supervisor at 360-292-4249**

**(*Questions? Contact Katherine at 360-704-7170 or klabranche@bhr.org)***