**\*\*\*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:**

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| --- | --- |
| 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  No  Bi-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  No  Please list any known diagnoses: Click here to enter text. | |
| Is the individual already receiving services for mental health?  Yes No  If 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  No  Please 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)***