EARLY PSYCHOSIS INTERVENTION REFERRAL FORM

Details of person being referred	
Date:	
Name:	
PHN:	
Date of Birth:	
Tel Number:	
Email Address:	
Address & Postal Code:	
GP: **Billing/MSP number (if referral from GP))**	
Next of Kin	
Name:	
Relationship:	
Address & Postal Code:	
Tel Number:	
Referrer's Details	
Name:	
Title:	
Address:	
Tel Number & Fax Number:	
Connection to Client (GP/Counsellor/Family member):	
School if (Applicable)	

CHECKLIST FOR PSYCHOSIS

Client Name:		**DOB:**	

Is the referred person aware of this referral to the EPI Team?	Yes ☐ No ☐

1 point each:-

The family is concerned	
Excess use of alcohol	
Use of street drugs	
Arguing with family and friends	
Spending more time alone	
Not attending school or work	
Sub total	

2 points each:-

Sleep difficulties	
Poor appetite	
Depressed or irritable mood	
Elevated mood	
Poor concentration	
Restlessness	
Tension or nervousness	
Loss of pleasure from things	
Not attending to hygiene	
Sub total	

3 points each:-

Feeling people are watching you*	
Feeling, hearing or seeing things other people cannot*	
Sub total	

5 points each:-

Ideas of reference* (believing that unrelated or innocuous things relate directly to them)	
Odd beliefs* (beliefs that don't match reality or make sense)	
Odd manner of thinking or speech	
Inappropriate mood	
Odd behaviour or appearance	
Family history of psychosis in parents/siblings/grandparents	
Sub total	
TOTAL	

- 20 points or more: refer to EPI for assessment
- If * item applies: refer to EPI even if total score is less than 20
- Is this person's first contact with mental health services? YES/NO
- Is this person aged between 13-35 years? YES/NO

PLEASE PROVIDE AS MUCH DETAIL AS POSSIBLE ON THE ATTACHED SHEET

Please forward this form to:

VICTORIA EARLY PSYCHOSIS SERVICE
Please fax referral to **250-370-8199** or call EPI Intake Clinician at 250-519-1936

Client Name:		DOB:	

Additional Information – If Known

Current Concerns – Please describe the current concerns that has you referring to the EPI program. Please include how long this has been happening.

Past mental health history – hospitalizations, diagnosis, suicide attempts

Family Mental Health History:

Medication History: **(ie hx of concussions/surgeries)**

Current medications – including over the counter, alternative medications

Past Medications:

Substance Use Issues: (please describe)

Child Protection Issues:

Child Custody Issues:

Criminal history

Support networks

Any Issues related to communication:

Please provide any additional information (feel free to use the back of this page on the back of this page):

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