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)	

VICTORIA EARLY PSYCHOSIS SERVICE
To submit referral Email VictoriaEPIIntake@islandhealth.ca OR
Fax referral form to 250-519-3424 OR
Call EPI Intake Clinician 250-519-3856 OR
If coming from internal Island Health program – **use Pathways**

To learn more about EPI and its services visit: https://www.earlypsychosis.ca/island-health/greater-victoria/

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CHECKLIST FOR PSYCHOSIS

Client Name:		**DOB:**	

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

See guide at back of form for explanation of frequency, duration, severity, and other terms

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:- (**Elaborate on these symptoms in Frequency, Duration, and Severity of Symptoms box below)**

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

5 points each:- (**Elaborate on these symptoms in Frequency, Duration, and Severity of Symptoms box below)**

Ideas of reference*	
Odd beliefs*	
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 ☐
  (EPI only accepts within this age range)

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PLEASE PROVIDE AS MUCH DETAIL AS POSSIBLE

Client Name:		DOB:	

Current Concerns – Please describe the current concerns that has you referring to the EPI program.

Timeline – Please indicate date with description of symptoms at each time.

Date of first symptoms:

Date of worst symptoms/onset:

Current Status:

Frequency, Duration, and Severity of Symptoms

Please check box that applies for each section.

Frequency:

- ☐ Less than once a month
- ☐ Once a month to twice a week
- ☐ 3-6 times a week
- ☐ Once daily
- ☐ Several times a day

Please elaborate:

Duration:

- ☐ Less than one hour per occasion
- ☐ More than one hour per occasion
- ☐ Continuous

Please elaborate:

Severity

- ☐ No symptoms
- ☐ Subtle changes
- ☐ Feeling perplexed by what's happening
- ☐ Behaviour is changing due to what's happening, but still questioning if it is real
- ☐ Behaviour has completely changed, person is fully convicted

Please elaborate:

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Past mental health history – (ex: hospitalizations, diagnosis, suicide attempts)
Family Mental Health History:
Medication History: **(ex: history 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:

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EARLY PSYCHOSIS INTERVENTION REFERRAL FORM

Guide

Frequency: How often are symptoms occurring? How many times per week/per month/throughout the day?
Duration: How long do symptoms last for? For less than an hour, or more than an hour? How many hours at a time? Are symptoms continuous?
Severity: What impact are the symptoms having on daily life? Have occurrence of symptoms changed the behaviour of the person? Is the person realizing something is different or has changed? Are they perplexed by the symptoms or convinced it is all real?

Bizarre ideas: Person is experiencing things that are not possible in this reality. See 5 point section of psychosis checklist.
Ideas of reference: Feeling as though unrelated things happening around a person have special meaning to that person or are directly targeted towards them.
Non-Bizarre Ideas: Exaggerations of reality. What the person is feeling could be possible, but it is not actually happening. See 3 point section of psychosis checklist.
Odd beliefs: Beliefs that don't match reality or make sense.
Offset of symptoms: When symptoms start to not be as severe as the onset.
Onset of symptoms: When symptoms were most intense.