Referral Form

Fax completed form to: 519-527-8420

Phone: 519-527-8421 ext 4813

Name:	Referral Date:
Address:	Other Contact Details:
Phone #:	Permission to leave message: YES □ NO □
Date of Birth:	Health Card Number:
Referral Source:	Phone #:
Is the client aware of this referral: YES □ NO □	Does the client have any allergies: YES □ NO □ If yes, please list:
Family Physician:	Phone #:
Family Information (Next of Kin/Guardian):	
Phone #:	Involved in Supporting Client YES □ NO □
Are there any safety issues (suicide, violence, criminal issues):	

<u>Mandatory Eligibility Criteria:</u>

☐Individuals between the ages of 16-35

☐Individuals are experiencing symptoms of psychosis or early psychosis

- ☐Hallucinations (auditory, visual or other)
- ☐Delusions (paranoia, grandiosity, thought broadcasting and insertion, etc.)
- ☐Disorganized thinking/feeling confused, thoughts are fast or slow, difficulty concentrating, or following a conversation

☐Individuals have received either no previous treatment , or 6months or less treatment for psychosis

☐Resident of Huron or Perth County

Secondary Eligibility Criteria:

☐Negative Symptoms (apathy, anhedonia, attention, etc.)

☐Mood (depressed, euphoria, anxious, etc.)

☐Other: (sleep, energy, harm to self or others, etc.)

Exclusion Criteria:

- Individuals who have received anti-psychotic treatment for more than six months are not eligible for PEPP
- Symptoms not clearly explained by an organic brain syndrome or other medical disorders.

Medication Current and Historical:

Substance Use: YES □ NO □	Type and Frequency:
Involvement with other Agencies : YES □ NO □	Agency and Contact Info:

Please attach a detailed referral summary expanding upon presenting concerns/symptoms/history at the time of sending this referral.

Signature: