HURON PERTH HEALTHCARE ALLIANCE

HURON PERTH PEPP
Prevention and Early Intervention Program for Psychoses

ALEXANDRA MARINE & GENERAL HOSPITAL

Referral Form

Fax completed form to: 519-527-8420

Name:	Referral Date:
Address:	Is housing stable: YES □ NO □
	Risk of becoming homeless: YES □ NO □
Phone #:	Permission to leave message: YES □ NO □ Permission to leave details on message: YES □ NO □
Date of Birth:	Health Card Number: Version Code:
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/Nurse Practitioner:	Phone #:
Family Information (Next of Kin/Guardian):	Phone #:
Is the family identified above Involved in supporting the client? YES □ NO □	

Mandatory Eligibility Criteria:

- 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 6 months 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 consistently are not eligible for PEPP
- Symptoms not clearly explained by an organic brain syndrome or other medical disorders
- Diagnosis of Intellectual Developmental Disorder, neurological or other medical conditions associated with psychosis

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Medication Current and Historical:	
Are there any safety issues (suicide, violence, criminal issues)?	
Is there a history of trauma (violence, abuse, disaster)? If yes, please explain:	
Are they attending school? YES □ NO □ If yes, where:	
Current source of income: □ Employment □ Family □ Employment Insurance □ Social Assistance (OW/ODSP) □ No Income □ Other : _____	Are they employed? YES □ NO □ If yes, where: What type of employment do they hold? □ part-time □ full-time □ causal □ on sick leave
Substance Use: YES □ NO □ Please specify substance frequency of use, method of use, and how long they have been using:	
Involvement with other agencies : YES □ NO □	Agency name and contact information:
Involvement with the law: YES □ NO □	If yes, please list charges pending:
Please attach a detailed referral summary expanding upon presenting concerns/symptoms/history at the time of sending this referral.	
Signature:	