

CHAMPLAIN DISTRICT REGIONAL FIRST EPISODE PSYCHOSIS PROGRAM

REFERRAL FORM

INCOMPLETE REFERRALS WILL BE SENT BACK TO REFERRAL SOURCE

<p>Inclusion criteria: If patient meets all inclusion criteria, proceed with referral</p>	<p>Exclusion criteria: If patient has any exclusion criteria, <u>do not continue with referral</u></p>
<ul style="list-style-type: none"> <input type="checkbox"/> AGED 16 – 35 YEARS <input type="checkbox"/> PATIENT AGREES TO REFERRAL <input type="checkbox"/> SYMPTOMS OF PSYCHOSIS <input type="checkbox"/> SIX MONTHS OR LESS OF ANTIPSYCHOTIC TREATMENT <input type="checkbox"/> RESIDES WITHIN THE CHAMPLAIN DISTRICT 	<ul style="list-style-type: none"> <input type="checkbox"/> PSYCHOSIS SECONDARY TO MOOD DISORDER <input type="checkbox"/> PSYCHOSIS DUE TO SUBSTANCE USE DISORDER <input type="checkbox"/> EXTENSIVE FORENSICS INVOLVEMENT <input type="checkbox"/> DEVELOPMENTAL DELAY

Because it takes time to diagnose the underlying cause of psychosis, On-Track will provide two types of service:

1. **Initial assessment & treatment (typically within 3 months):** Through that assessment phase, On-Track will determine which clients will benefit from rehabilitation in our program and treatment, and which clients should be referred to other more appropriate services. Individuals who do not have a psychotic disorder will not be admitted to the program.
2. **Intensive treatment and rehabilitation services:** This will be provided to those individuals who meet our inclusion/eligibility criteria listed above.

***** PLEASE NOTE: *****

1. An incomplete referral form will not be processed.
2. Please ensure all supporting documentation is included with the referral.
3. We do not offer a prodromal clinic service.
4. We do not provide crisis management support during the referral process or wait list period.

Intake Team / On-track
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Ottawa, ON K1H 8K7

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Tel (613) 737-8899 ext. 73908 (Intake office)
Fax (613) 737-8318

FEPPintake@toh.ca

PATIENT INFORMATION	REFERRAL SOURCE INFORMATION
NAME	NAME
PHONE _____ (HOME) _____ (CELL) _____ (OTHER)	PHONE
ADDRESS _____ _____	FAX
LANGUAGE PREFERENCE <input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH <input type="checkbox"/> OTHER _____	ADDRESS
ONTARIO HEALTH INSURANCE NUMBER (OHIP) _____	RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> FAMILY MEMBER <input type="checkbox"/> FAMILY PHYSICIAN <input type="checkbox"/> PSYCHIATRIST <input type="checkbox"/> OTHER _____ *** NAME OF PRIMARY CARE PROVIDER *** _____ IS THE PRIMARY CARE PROVIDER AWARE OF THIS REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO
DATE OF BIRTH (DD-MM-YYYY) AGE _____ _____ GENDER <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> OTHER Does patient agree to this referral? <input type="checkbox"/> YES <input type="checkbox"/> NO A message can be left? (check all that apply) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> AT HOME <input type="checkbox"/> ON CELL <input type="checkbox"/> WITH FAMILY MEMBER <input type="checkbox"/> OTHER _____	
FAMILY / NEXT OF KIN / EMERGENCY CONTACT INFORMATION NAME _____ ADDRESS RELATIONSHIP _____ PHONE _____	

REASON FOR REFERRAL/TREATMENT GOALS:

SYMPTOM PROFILE: (check all that apply)

DESCRIPTION

DATE OF ONSET

- DELUSIONS
- HALLUCINATIONS
- DISORGANIZATION OF THINKING AND BEHAVIOUR
- FUNCTIONAL DECLINE
- APATHY, DECREASED MOTIVATION

DESCRIPTION	DATE OF ONSET
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SUBSTANCE USE:

- CANNABIS USE, FREQUENCY & AMOUNT
- STIMULANT, TYPE & FREQUENCY
- HALLUCINOGENS, TYPE & FREQUENCY
- ALCOHOL, AMOUNT & FREQUENCY
- OTHER

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICAL HISTORY (IF APPLICABLE)

HAS PATIENT RECENTLY BEEN HOSPITALIZED OR ASSESSED BY A PSYCHIATRIST?

- NO
- YES (PLEASE INCLUDE PAST PSYCHIATRIC DIAGNOSIS & HISTORY, AVAILABLE COLLATERAL AND DISCHARGE SUMMARY OR ASSESSMENT REPORT)

CURRENT MEDICATION:

MEDICATION	DOSE	DURATION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE ACKNOWLEDGE EACH STATEMENT BELOW BY INITIALING THE CORRESPONDING BOX

	Referring General Practitioners/Primary Care Providers will continue serving as the primary care provider and will assume psychiatric care when the patient has been stabilized and completed their term at <i>On Track</i>
	Referring specialists will remain involved in care or make alternate care arrangements until confirmation of enrolment is received.

Name (print)

Signature

Date (dd-mm-yyy)

INCOMPLETE REFERRALS WILL BE SENT BACK TO REFERRAL SOURCE

**Please ensure all supporting documentation (i.e. assessment reports, discharge summaries) are included with the referral
CLIENTS WILL NOT BE CONTACTED UNTIL ALL SUPPORTING DOCUMENTATION IS RECEIVED**

Helpful resources:

Need a doctor?
Health Care Connect
www.ontario.ca
1-866-538-0520

Mental Health Crisis Line
www.crisisline.ca
(613) 722-6914 (Ottawa resident)
1-866-996-0991 (Champlain District)

- Psychosis information:
- www.Help4psychosis.ca
 - www.psychosis101.ca
 - www.earlypsychosis.ca
 - www.ementalhealth.ca/

