The Ottawa Hospital
L'Hôpital d'Ottawa

Champlain District Regional
First Episode Psychosis Program
Programme premier épisode de psychose
du district régional Champlain

CHAMPLAIN DISTRICT REGIONAL FIRST EPISODE PSYCHOSIS PROGRAM

REFERRAL FORM

INCOMPLETE REFERRALS WILL BE SENT BACK TO REFERRAL SOURCE

Inclusion criteria: If patient meets all inclusion criteria, proceed with referral	**Exclusion criteria:** If patient has any exclusion criteria, do not continue with referral
☐ AGED 16 – 35 YEARS ☐ PATIENT AGREES TO REFERRAL ☐ SYMPTOMS OF PSYCHOSIS ☐ SIX MONTHS OR LESS OF ANTIPSYCHOTIC TREATMENT ☐ RESIDES WITHIN THE CHAMPLAIN DISTRICT	☐ PSYCHOSIS SECONDARY TO MOOD DISORDER ☐ PSYCHOSIS DUE TO SUBSTANCE USE DISORDER ☐ EXTENSIVE FORENSICS INVOLVEMENT ☐ 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
1355 Bank Street, Suite 208
Ottawa, ON K1H 8K7

FEPPintake@toh.ca

Tel (613) 737-8069 (Main office/reception)
Tel (613) 737-8899 ext. 73908 (Intake office)
Fax (613) 737-8318

PATIENT INFORMATION

NAME

PHONE

_____(HOME) _____ (CELL) _____ (OTHER)

ADDRESS

_____

_____

LANGUAGE PREFERENCE

- □ ENGLISH
- □ FRENCH
- □ OTHER

_____

ONTARIO HEALTH INSURANCE NUMBER (OHIP)

_____

DATE OF BIRTH (DD-MM-YYYY) AGE

_____ _____

GENDER □ M □ F □ OTHER

Does patient agree to this referral? □ YES □ NO

A message can be left? (check all that apply) □ YES □ NO

- □ AT HOME
- □ ON CELL
- □ WITH FAMILY MEMBER
- □ OTHER

_____

REFERRAL SOURCE INFORMATION

NAME

PHONE

FAX

ADDRESS

RELATIONSHIP TO PATIENT

- □ SELF
- □ FAMILY MEMBER
- □ FAMILY PHYSICIAN
- □ PSYCHIATRIST
- □ OTHER

_____

***** NAME OF PRIMARY CARE PROVIDER *****

_____

IS THE PRIMARY CARE PROVIDER AWARE OF THIS REFERRAL?

- □ YES
- □ NO

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	_____	_____
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 ACKNOLEDGE 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 *On Track*
	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/