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

REFERRAL SOURCE INFORMATION	
Name:	**Organisation:**
Phone Number/Ext:	**Address:**
Designation:	**Departmental Fax Number:**
Relationship to Patient ☐ Self ☐ Family Member/ Friend ☐ Family Physician ☐ Psychiatrist Other: _____	

As diagnosing an underlying cause of psychosis could be a lengthy process, OnTrack First Episode Psychosis Program (FEPP) will provide two types of services:

1. **Initial assessment (typically within 3 months):** OnTrack will determine which clients will qualify for services in our program and which clients should be referred to other more appropriate services. Individuals who do not have a primary psychotic disorder will not be enrolled to the program.
2. **Intensive treatment and rehabilitation services:** This will be provided to those individuals who meet our inclusion/eligibility criteria listed below.

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

1. An incomplete referral form will not be processed.
2. Please ensure all supporting documentation are attached to 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 / OnTrack
1355 Bank Street, Suite 208
Ottawa, ON K1H 8K7

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

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Client Information	*** Please Check All That Apply ***
Name:	**Inclusion Criteria** ☐ Aged 16 – 35 years ☐ Patient agrees to referral ☐ First episode of psychosis ☐ Resides within the Champlain District
Please identify possible means for contacting client including alternate Family/Next of Kin in the section below **Telephone Number:** (Home) _____ **Telephone Number:** (Cell) _____ Does the client consent to voicemail messages? ☐ Yes ☐ No	**Exclusion Criteria** ☐ Psychosis secondary to mood disorder ☐ Psychosis solely due to substance use disorder. ☐ Extensive forensics involvement ☐ Intellectual disability
Email address:	
Address:	
Date of Birth (DD-MM-YYYY) **Age** **Gender** ☐ Male ☐ Female Other: _____	**Language Preference:** ☐ English ☐ French Other: _____ Translator required? ☐ Yes ☐ No
Ontario Health Insurance Number (OHIP) _____	**Name of Patient's Primary Care Provider** **Is the primary care provider aware of this referral?** ☐ Yes ☐ No

Family/Next of Kin/Emergency Contact Info (Please ensure this is filled out so we can try all avenues to contact)

Name _____

Relationship _____

Address _____

Phone _____

Does the client provide consent to voicemail messages at Family/Next of Kin/Emergency Contact, if unable to reach them directly? ☐ Yes ☐ No

Reason For Referral/Treatment Goals:

Please describe psychotic symptoms and approximate date of onset:

Has patient recently been hospitalized or assessed by a psychiatrist?

☐ No

☐ Yes (please attach past psychiatric diagnosis & history, available collateral and discharge summary or assessment report)

Previous psychiatric hospitalizations:

Previous psychiatric treatment:

Substance use history:

Substance _____ Past or Current? _____ Amount/frequency _____

Substance _____ Past or Current? _____ Amount/frequency _____

Substance _____ Past or Current? _____ Amount/frequency _____

Substance _____ Past or Current? _____ Amount/frequency _____

Substance _____ Past or Current? _____ Amount/frequency _____

Current Medication:

Medication	Dose	Start Date

PLEASE ACKNOWLEDGE EACH STATEMENT BELOW BY INITIALING THE CORRESPONDING BOX

	The client/patient consents to this referral
	Referral does not guarantee enrolment. Care plans must be in place until enrolment is confirmed (prescriptions, administration of injections, etc.)
	Referring 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 OnTrack.
	The OnTrack FEPP is a limited duration subspecialty program for up to three years depending on treatment goals and engagement.

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)

Suicide Crisis Helpline: https://988.ca/
988 (Canada-wide helpline)

Psychosis Information:
www.help4psychosis.ca
www.psychosis101.ca
www.earlypsychosis.ca
www.ementalhealth.ca/
https://www.accessmha.ca/