APPLICATION FOR SERVICE

CMHA Early Psychosis Intervention (EPI) Team was created to help young adults receive support with their first episode of psychosis. When support is offered at the first sign of symptoms, there is less disruption to social and family relationships, decreased risk of hospitalization, and recovery is faster and more complete. Service is provided by a multi-disciplinary team, which includes a Psychiatrist, Social Worker, Registered Nurse, Occupational Therapist, Family Support Worker, Peer Support Worker, FNMI Liaison, Mental Health Workers and an Addictions Specialist.

Anyone is welcome to make a referral to the EPI team by reviewing the intake criteria below and completing the referral form. If you do not think the EPI is right for you but still require support with mental health, please call our central intake line at (705) 726-5033 or the CMHA Crisis Line at (705) 728-5044.

Inclusion Criteria	Yes	No
14-35 years of age	☐	☐
Currently experiencing symptoms of psychosis	☐	☐
Experienced a recent decrease in socialization, motivation, change in thought process	☐	☐
Have symptoms been treated with medication for 6 months or more?	☐	☐

Mail or fax the completed Referral Form to the address and fax number below:

Early Psychosis Intervention Program
134 Anne Street South
Barrie, ON L4N 1W2
Phone: (705) 726-5033
Fax: (705) 725-5496

** PLEASE NOTE: Our referral process has changed. If the referral for service is being completed by a Health Care Professional in an Acute or Community setting, there is a list of **mandatory documentation** (listed in Section G) that must accompany the application. If you have any questions about this process, please contact the EPI Program at (705) 726-5033.

Canadian Mental Health Association
Association canadienne pour la santé mentale
Simcoe County
GAMBLING, SUBSTANCE USE & MENTAL HEALTH SERVICES

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Early Psychosis Intervention Program

Referral Form

Please complete sections A – G

Please ensure that you have reviewed the accompanying Application for Service to ensure the applicant qualifies for this service.

DATE OF REFERRAL: _____

Referral Completed by: ☐ Health Care Professional ☐ Family/Self ☐ Other: _____

A/ REFERRAL SOURCE

Name: _____ Agency: _____

Address: _____

Tel: _____ Ext: _____ Fax: _____

Email: _____

Please note: A referral does not guarantee Program admission. We ask that you continue to provide clinical support to the referred individual until we have completed our assessment and confirmed that the client has been accepted into the EPI program.

<u>If the referral is being completed by a Health Care Professional in an Acute and/or Community setting, please ensure the mandatory documentation is attached to the referral form (please see Section G for a complete list).</u>

Please fax recent lab results and relevant reports e.g. medical records, discharge summary etc. Fax to (705) 725-5496

B/ PERSONAL & CONTACT INFORMATION

Surname: _____ Given Name: _____

Date of Birth: (mm/dd/yy) _____

Gender: ☐ Male ☐ Female ☐ Trans (Male to Female) ☐ Trans (Female to Male) ☐ Other (please specify): _____

Health Card Number: _____ VC: _____ Expiry Date: _____

Preferred Language: ☐ English ☐ French ☐ Other, please specify _____

Street address: _____

Apt. No: _____ Entry Code: _____ City: _____ Province: _____ Postal Code: _____

Telephone No: _____ Ext: _____

Email: _____

Is the Client aware of the referral and have you obtained explicit consent (written or verbal) from the client or their Substitute Decision Maker for this referral? ☐ Yes ☐ No ☐ Unknown

Does the client consent to communication with family members? ☐ Yes ☐ No ☐ Unknown

Can we leave a confidential voice message or with someone at this number? ☐ Yes ☐ No ☐ Unknown

Can we identify as a CMHA employee? ☐ Yes ☐ No ☐ Unknown

Are there any accessibility concerns? ☐ Yes ☐ No ☐ Unknown Details: _____

Are there safety concerns? ☐ Yes ☐ No ☐ Unknown
If YES or UNKNOWN, please include details/comments: _____

Are there pets in the home? ☐ Yes ☐ No ☐ Unknown What pets: _____

Is there smoking in the home? ☐ Yes ☐ No ☐ Unknown

If currently hospitalized:
Attending Physician: _____ Tel: _____ Fax: _____

C/ REASONS FOR REFERRAL

Symptoms of Psychosis	None	Yes, provide details	Time Frame
Hallucinations (auditory, visual, tactile, olfactory, gustatory)	☐		
Delusions (grandiose, persecutory, religious, control, somatic, reference, thought insertion/withdrawal, mind reading)	☐		
Suspiciousness and paranoia	☐		
Mood			
Low mood, poor sleep and appetite, a change in enjoyment of activities	☐		
Elevated mood, risk taking behaviour, racing thoughts, poor sleep, excessive spending	☐		
Functioning			
Decline in functioning at school and/or work or home	☐		
Social withdrawal, isolation, other change	☐		
Uncharacteristic personality change	☐		
Disorganized thinking	☐		
Risk			
Agression or violence towards others	☐		
Homicidal ideation	☐		
Self Harm	☐		
Suicide	☐		
Substance Use	☐		
Past/Current Legal Issues (includes diversion)	☐		

When were concerns/changes first noticed: _____

D/ CO-MORBID MEDICAL ILLNESS and HISTORY

Injury, condition or procedure	None	If yes, provide details	Time Frame
Head injury or concussions	☐		
CT SCAN	☐		
Pre-existing medical condition (ie. diabetes, thyroid etc.)	☐		
Baseline blood work completed	☐		
Has the individual been identified on the spectrum of a Global delay	☐		

E/ TREATMENT, MEDICATION and FAMILY HISTORY

Have there been any hospitalizations in the past for these concerns? ☐ Yes ☐ No ☐ Unknown

If yes, list the psychiatric hospitalizations:

Name of Hospital	Admission Date	Reason for Admission	Discharge Date	Discharge Status & Plan

Is the client currently involved with a Psychiatrist? ☐ Yes ☐ No ☐ Unknown
If yes, please provide the following information on the Psychiatrist:
Name: _____ Tel: _____ Fax: _____
Length of time: _____

If not currently involved with a Psychiatrist, please report when the individual was last seen by a Psychiatrist:
Date: _____ ☐ Never

Is there a Mental Health Diagnosis? ☐ Yes ☐ No ☐ Unknown
If yes, please provide details (e.g. diagnosis, assessments, hospital records) _____
_____

Does the client have a Family Physician? ☐ Yes ☐ No ☐ Unknown
If yes, please provide the following information on the physician:
Name: _____ Tel: _____ Fax: _____

Please complete the following list for all current medications being used?
(e.g. psychiatric, non-psychiatric, herbal supplements etc.)

Drug Name	Dosage	Duration

Pharmacy Name/Address: _____ Tel: _____ Fax: _____

Family History	None	Yes, please provide details and treatment if any:	Time Frame
Psychiatric History	☐		
Substance Use History	☐		
Suicide History	☐		
Physical Health History	☐		

F/ SUPPORTS & SERVICES

Is the Client currently working with any other service providers? ☐ Yes ☐ No ☐ Unknown
If yes, please provide the following information on each service provider with whom the client is working:

Agency	Name/Contact Person	Service(s) Received	Telephone Number

Please identify any family/friends or supports which the client would like to involve in the Care Planning with EPI:

Name	Telephone Number	Relationship	Permission to Contact
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Emergency Contact Name: _____ Relationship: _____
Tel: _____ Email: _____

Has an Ontario Common Assessment of Need (OCAN) been completed? ☐ Yes ☐ No ☐ Unknown

Aboriginal Origin: ☐ Aboriginal ☐ Non-aboriginal ☐ Declined to Answer ☐ Unknown

Culture/Ethnicity: _____ Citizenship/Immigration status: _____

What is the highest grade/level of education the client has completed? _____
What is his/her current education status?

☐ No formal schooling ☐ Secondary/High School ☐ Some College/University
☐ Some elementary/Jr. High ☐ Some secondary/high school ☐ College/University
☐ Unknown/Declined

G/ SUPPORTING DOCUMENTATION

In order for us to process this referral in a timely manner, it is essential that we receive as much collateral information as possible.

The following documentation is mandatory if referral is sent from a Health Care Professional:

- ☐ Hospital Documentation
  - Admission notes
  - Psychiatric Consultation Notes
  - Treatment Plan(s)
  - Discharge Summary
- ☐ Baseline blood work
- ☐ CT Scan Results

If you have the following available to you, please forward them with the referral for service:

- ☐ OT Assessments
- ☐ Psychological Assessments
- ☐ Educational Support Plans

Include any other documentation that you feel would be of benefit to the Early Psychosis Intervention Team.

APPLICANT AND REFERRER'S DECLARATION & CONSENT

Consent Forms allowing communication between the referral source and the CMHA Simcoe Branch EPI Program Services has been included? ☐ Yes ☐ No

I have discussed this referral with the client and the client agrees with the submission of this referral.

Referrer's signature: _____ Date: _____

*Applicant's signature: _____ Date: _____

Substitute Decision Maker (SDM) signature: _____ Date: _____

Not necessary to process the application.

FOR OFFICE USE ONLY:

Date Referral Received: _____

EMHWare File Created: ☐ Yes ☐ No

Program History Started: ☐ Yes ☐ No

Has the referral source been contacted within 72 hours? ☐ Yes ☐ No

Date of Intake: _____

Please provide a copy of this sheet to the referral source, families and/or the client.

Referrals to the Early Psychosis Intervention (EPI) program:

Please note that anyone can make a referral to our program.

Referral Process - What to expect

Step 1 Fill out a referral. If making a referral for someone else, when possible it is a good idea for the person being referred to be aware of and/or involved in this initial conversation.

Step 2 An EPI staff member will contact the referral source within 72 hours to notify them the application has been received and to gather any other information. If the individual being referred meets the criteria for the Early Intervention service the EPI worker will arrange to meet with them within the next two weeks. The purpose of meeting is to gain a better understanding of the person's situation, thought-process and to discuss options available through the Early Intervention service. If the individual does not meet the criteria of the EPI, they will be provided with other resources.

Step 3 The EPI worker will meet with the individual. The individual can decide where the meeting takes place (at home, at our office, school, coffee shop) and whom they want to invite to the meeting (parents, sibling, friend).

Step 4 All information gathered will be viewed by our team of mental health professionals (peer support worker, occupational therapist, social worker, nurse, etc.) in a process the team calls clinical rounds. This process is used to determine treatment recommendations inclusive of services outside of an EPI program.

Step 5 If after the initial assessment, the individual would not be best supported by an EPI program, they will be provided with more appropriate resources in the community and further recommendations. If after the initial assessment, the individual would be best supported by an EPI program and a decision is made to continue, the individual will be assigned a primary care coordinator (case manager). At the end of the assessment, the psychiatrist gives feedback and recommendations for treatment and follow-up.

Step 6 The individual and his/her family will be partnered with clinicians from the EPI service for ongoing follow-up, education, support and treatment. The family will also have the opportunity to be connected to a family support worker to support them during this process and their loved one's recovery. Each individual's recovery plan looks different and is based on their goals.

If in the mean time you require immediate support please call our 24 hour crisis line @ 705-728-5044. If it is an emergency call 9-1-1 or visit your local emergency department.

Y-PAR-Q

These questions are about the kind of person you generally are—that is, how you have usually felt or behaved over the past several years. Mark "**Y**" for **yes** if the question completely or mostly applies to you, mark "**N**" for **no** if the question completely or mostly does **not** apply to you and mark "**U**" if you are undecided. If you do not understand a question or do not want to answer it, leave it blank.

	Y	N	U
1. Are you more superstitious than other people?			
2. Do you hold beliefs that others would find unusual or different or bizarre?			
3. Do you ever feel you can predict the future?			
4. Have you felt that something outside yourself has been controlling your thoughts, feelings, or actions?			
5. Do you ever feel that the world does not exist?			
6. Do familiar surroundings sometimes seem threatening to you?			
7. Have you ever felt that some person of force interferes with your train of thinking?			
8. Are your thoughts broadcast so that other people know what you are thinking?			
9. Do you ever feel people are plotting against your or planning to harm you?			
10. Do you feel you have unusual healing abilities or powers?			
11. Do things sound softer than usual to you?			
12. Do you ever hear the voice of someone talking that other people cannot hear?			
13. Do things that you see appear different in colour, brighter or duller or in some other way changed?			
14. Is it hard to establish a connection or feel at a distance when you are talking with others?			
15. Have you noticed any unusual bodily sensations such as tingling, pulling, pressure, burning, cold, vibrations, drilling, tearing or electricity?			
16. Do people ever say you do odd or strange things?			
17. Have you felt at a distance from yourself, as if you were outside your own body?			
18. Do you tend to avoid social activities with others?			
19. Do you ever hear sounds that are not there?			
20. Do familiar surroundings sometimes seem unreal to you?			
21. Do you ever feel that things or parts in your body are working differently?			
22. Do you see things that others can't or don't see?			
23. Have you ever felt that you don't exist or are dead?			
24. Do you get strange feelings on or just beneath your skin?			
25. Have you had the sense that some person or force is around you, even though you cannot see anyone?			
26. Do things sound louder than usual to you?			
27. Do people ever say your ideas are strange or don't make sense?			
28. Have you ever felt that someone was playing with your mind?			