Application for Service

Anyone is welcome to make a referral to the EPI team by reviewing the intake criteria below and completing the referral form. If you are unsure that the EPI program is right for you but still require support with mental health, please call Central Intake at (705) 726-5033 or the CMHA Crisis Line at (705) 728- 5044.

Please fax the completed Referral Form to: 705-725-5496

Note: A referral does not guarantee admission and follow-up by our team. We ask that you continue to provide clinical support to the referred individual until we have completed our assessment and determined program involvement.

Inclusion Criteria

- ☐ Person is between the age of 14-35 and resides in Simcoe County
- ☐ Person has been diagnosed with a psychotic or likely psychotic disorder and symptoms of psychosis is the primary issue or concern
- ☐ Person has experienced recent symptoms of a first episode of psychosis for less than one year and/or has received 6 months or less treatment for psychosis
- ☐ Person is aware the referral is being made for them and is agreeable to services

Exclusion Criteria

- **Developmental and/or Intellectual Disability**
- **Autism Spectrum Disorder**
- **Substance Induced Psychosis**
- **Ongoing forensic involvement that would prevent the individual from participating in the program**
- **The complexity of the case is beyond the capacity of the team to safely manage in the community**

Relevant Documents (Please Attach to the Referral)

- ☐ Psychiatric assessment/ consultation notes
- ☐ Previous hospital psychiatric notes/ Other relevant documentation
- ☐ Psychological reports
- ☐ Discharge summary
- ☐ MAR sheet (Medication Records)

NOTE: FAILURE TO INCLUDE RELEVANT INFORMATION AND DOCUMENTS WTIH THIS REFERRAL WILL DELAY THE REFERRAL PROCESS

Canadian Mental Health Association
Simcoe County
Gambling, Substance Use and Mental Health Services

Referral Form

Date of Referral:

Referral Completed By: ☐ Health care Professional ☐ Family/Self ☐ Other

Personal and Contact Information

Surname:

Given Name: :

Date of Birth:

Gender Identity:

Health Card No:

VC:

Expiry:

Preferred Language:

Address:

Telephone No:

E-Mail:

Applicant's Signature:

Referral Source

Name:

Agency:

Address:

Telephone No:

Fax No:

E-Mail:

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

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

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

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Name:

Reasons for Referral

SYMPTOMS

Hallucinations:
- ☐ Auditory
- ☐ Visual
- ☐ Tactile
- ☐ Olfactory
- ☐ Gustatory

☐ None

Details & Time Frame:

Delusions:
- ☐ Grandiose
- ☐ Persecutory
- ☐ Religious
- ☐ Control
- ☐ Somatic
- ☐ Reference
- ☐ Insertion
- ☐ Mind reading

☐ Suspiciousness/ paranoia:

☐ None

Details & Time Frame:

MOOD

- ☐ Low mood
- ☐ Poor sleep
- ☐ Poor appetite
- ☐ Change in activities

☐ None

Details & Time Frame:

- ☐ Elevated mood
- ☐ Risk taking
- ☐ Racing thoughts
- ☐ Excessive spending

☐ None

Details & Time Frame:

FUNCTIONING

Decline in functioning at:
- ☐ School
- ☐ Work
- ☐ Home
- ☐ Social withdrawal
- ☐ Isolation
- ☐ Personality change
- ☐ Disorganized thinking

☐ None

Details & Time Frame:

RISK

- ☐ Aggression or violence towards others
- ☐ Homicidal Ideation
- ☐ Self Harm
- ☐ Suicide
- ☐ Substance Use
- ☐ Past/Current Legal Issues (includes diversion)

☐ None

Details & Time Frame:

Canadian Mental Health Association
Simcoe County
Gambling, Substance Use and Mental Health Services

Name:

Co-Morbid Medical Illness and History

- ☐ Head Injury or Concussions
- ☐ CT Scan
- ☐ Pre-Existing Medical Condition
- ☐ Baseline Bloodwork Completed

Details & Time Frame:

Treatment, Medication and Family History

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

If yes, please list the psychiatric hospitalizations:

Name of Hospital:	Admit Date:	Reason for Admission:	Discharge Date:	Discharge Status and Plan:

Is the client currently involved with a Psychiatrist? ☐ Yes ☐ No ☐ Unknown

If yes, please provide the following information on the Psychiatrist:

Name: Telephone No:

Fax No: Length of Time:

If not currently involved with a Psychiatrist, please report when the individual was last seen by a Psychiatrist:

Date: ☐ Never

If the individual is currently hospitalized, please provide the following information on the attending Physician:

Name: Telephone No: Fax No:

Is there a mental health diagnosis? ☐ Yes ☐ No ☐ Unknown

Details & Time Frame:

Canadian Mental Health Association
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Name:

Does the client have a Family Physician? ☐ Yes ☐ No ☐ Unknown

If yes, please provide the following information on the physician:

Name: Telephone No: Fax No:

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: Telephone No: Fax No:

Family History

☐ Psychiatric History
☐ Substance Use History
☐ Suicide History
☐ Physical Health History

☐ None

Details & Time Frame:

Supports And 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:

Emergency Contact Name: Relationship:

Telephone No: E-Mail:

Aboriginal Origin: ☐ Aboriginal ☐ Non-Aboriginal ☐ Unknown ☐ Declined To Answer

Culture/Ethnicity: Citizenship/Immigration Status:

Highest Grade Level Completed:

Current Education Status:

☐ No Formal Schooling
☐ Some Elementary/Jr. High
☐ Some Secondary/High School
☐ Secondary/High School
☐ Some College/University/Trade
☐ College/University/Trade
☐ Unknown/Declined