



**Please be sure to fill in all mandatory information. Incomplete referrals will be sent back to sender for completion.*

Program Criteria: The Early Intervention (EPI) program serves individuals 14–35 years old, residing in Windsor-Essex County, who have experienced a recent onset of psychosis symptoms. Individuals must have had fewer than 3 years of prior EPI treatment and fewer than 5 years elapsed since the initial diagnosis of a psychotic illness. Individuals must be aware of and agreeable to, an EPI assessment and participation in a program where a team of professionals works together to support and guide care for up to 3 years.

Client/Patient Information

Last Name:		First Name:	(name on health card)		
Preferred Name:					
Please select:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other		
Date of Birth	date				
Address:					
Phone:		Email:			
Health Card #:		Version Code:			

Referral Source (please attach all recent assessments, consults and documentation for our file)

<input type="checkbox"/> Agency	<input type="checkbox"/> Doctor's Office	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Other		
Physician's Name:					
Physician Billing #:					
Telephone:					
Address:					
Fax:					
Date:	date				
Primary Care Provider:		Phone:			

Family Member or Care Partner Information

Relationship:					
Name:					
Telephone:					
Consent to Speak with Family Member or Care Partner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Permission to leave voicemail or msg. with household member	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Language Spoken					

Clients Living Arrangements:

<input type="checkbox"/> Alone	<input type="checkbox"/> Shared	<input type="checkbox"/> Family
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Safety Concerns

<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, what are these concerns:	



Supporting documentation must be provided for all points below for the referral to be processed:

<input type="checkbox"/>	Psychiatric Diagnosis and/or Symptoms
<input type="checkbox"/>	Recent relevant physician notes, admissions and discharge summaries
<input type="checkbox"/>	Hospital or Inpatient Discharge Summaries
<input type="checkbox"/>	History - previous hospital admissions, psychiatric treatment history, psychological testing and/or any previous testing or other treatment, legal or other relevant documentation
<input type="checkbox"/>	Consents

Current Medications (or attach an updated list of medications)

Medication	Dose	Duration

Hospital Admissions

Current Admission	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Admission Date:	date			
Discharge Date:	date			
Number of Days in Hospital:				
Date of Last Admission:	date			
Number of days spent in hospital during las admission:				
Any previous admissions:				

Other Diagnoses/Concerns:

These are not necessarily exclusionary; for assessment/treatment purposes only.

<input type="checkbox"/>	Medical Conditions	
<input type="checkbox"/>	Substance Use Issues (including frequency)	
<input type="checkbox"/>	Developmental Delay (if known)	
<input type="checkbox"/>	Learning Difficulties (if known)	
<input type="checkbox"/>	Other (specify)	
<input type="checkbox"/>	Justice System Involvement	

Are there any current appointments for follow up?

If so, include **Date**, **Time**, and **Purpose** i.e., medication (LAI's), outpatient appts (e.g. B4 clinic), other physicians, programming, other referrals, etc.

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It is important to note: (please check when read)

<input type="checkbox"/>	This program is not designed for urgent or emergency situations. If the client is experiencing an immediate crisis or if urgent support is needed, please contact the crisis centre at 519-973-4435.
<input type="checkbox"/>	The outcome status of this referral will be communicated to the referral source.
<input type="checkbox"/>	It is expected that the referring specialist/physician is required to remain involved in care or make alternate care arrangements until client has been accepted from waitlist into service with EIP. A referral to EIP does not guarantee acceptance nor that treatment will be provided.
<input type="checkbox"/>	It is expected that a referring primary care provider will assume follow-up (psychiatric) care when client is stabilized and discharged from EIP.

Form Completed by:			
Name:			
Phone Number:		extension	
Other Contact Information			