EPIC-NOLA

EARLY PSYCHOSIS INTERVENTION CLINIC

REFERRAL FORM					
ELIGIBILITY CRITERIA: *1. BETWEEN THE AGES 12-35 (WE ARE AVAILABLE TO DISCUSS THOSE OUTSIDE OF THIS AGE RANGE)* *2. HAVE BEEN EXPERIENCING PSYCHOSIS FOR LESS THAN 3 YEARS* *3. HAVE RECEIVED A DIAGNOSIS OF SCHIZIPHRENIA OR OTHER PSYCHOTIC DISORDER, EVEN IF UNSPECIFIED* *4. WILLINGNESS TO BE EVALUATED AND TREATTED BY HEALTHCARE PROFESSIONALS*					
Date		**Client Name**			
DOB		**Age**		**Gender**	
Address					
Telephone #		**Alternate #**			

Name of Caller		**Relationship to Client**	
Organization		**Email address**	
Insurance Provider		**Member ID**	

REFERRER INFORMATION (CIRCLE ALL THAT APPLY)			
Inpatient psychiatric hospital	Outpatient mental health clinic-psychiatrist	Outpatient mental health-therapist	Outpatient health-pediatrician
Outpatient health-adult medicine	School-based health	Emergency Room	Justice System
Self	Family/Friend	Other:	
Name of Referral Organization (i/a)			

HOW DID YOU HEAR ABOUT EPIC-NOLA?					
Have you heard of our psychosis early detection campaign, CALM-Clear Answers to Louisiana Mental Health? (if yes, please answer below)				**YES**	**NO**
Social Media IG FB YT TWITTER	**Google (Term searched?)**	**Ad**	**Website**	**Other:**	
Have you taken the quiz on www.calmnola.org?				**YES**	**NO**

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INFORMATION ABOUT THE REFERRED INDIVIDUAL				
Are they currently in treatment?	YES	NO	If YES, who is the provider?	
Current Diagnosis (if applicable)?				
Are they taking medications?	YES	NO	If YES, what are they	
Have they been hospitalized for psychiatric reasons?	YES #_____	NO	If YES, When and where?	

PSYCHOSIS INFORMATION: IS THE INDIVIDUAL YOU ARE REFERRING EXPERIENCING ANY OF THE FOLLOWING?		
Changes in thinking (odd ideas, grandiosity, suspiciousness, difficulty concentrating)	YES	NO
Changes in perception (auditory/visual/tactile/smell abnormalities)	YES	NO
Changes in speech (disorganized communication, changing topics, not making sense)	YES	NO
Emotional changes (depression, mood swings, irritability, lack of emotional expression)	YES	NO
Dramatic reduction in overall functioning (decline in personal hygiene, decline in school or work abilities)	YES	NO
Family history of severe mental illnesses (_____)	YES	NO
Any medical conditions involving head injuries or seizures?	YES	NO
Special education/IQ issues	YES	NO
Estimated date of onset of the above symptoms?		

FRIENDS AND FAMILY OR SELF REFERRAL ADDITIONAL INFORMATION
Please describe what you or your loved one has been experiencing over the past month?
How did you or your loved one function before the onset of these symptoms?