FOR OFFICE USE ONLY

MRN# _____ Consult date _____

Intake PC _____ Consult MD _____

Acuity _____ Consult PC _____

Champlain District Regional
First Episode Psychosis Program
Programme premier épisode de psychose
du district régional Champlain

REFERRAL FORM
CHAMPLAIN DISTRICT REGIONAL FIRST EPISODE PSYCHOSIS PROGRAM

1355 Bank Street – 2nd Floor – Suite 208 – Ottawa – Ontario – K1H 8K7
TEL (613) 737-8069 FAX (613) 737-8318

PATIENT INFORMATION	REFERRAL SOURCE INFORMATION
NAME	NAME
PHONE _____(HOME) _____(CELL) _____(OTHER)	PHONE
ADDRESS	FAX
LANGUAGE PREFERENCE ❒ENGLISH ❒FRENCH ❒BILINGUAL ❒OTHER _____	ADDRESS
HEALTH INSURANCE NUMBER DATE OF BIRTH (DD/MM/YYYY) AGE GENDER ❒M ❒F ❒OTHER _____	**RELATIONSHIP TO PATIENT** ❒SELF ❒FAMILY MEMBER ❒FAMILY PHYSICIAN ❒PSYCHIATRIST ❒OTHER _____
Is patient aware of this referral? ❒YES ❒NO A message can be left ❒AT HOME ❒ ON CELL ❒AT OTHER ❒WITH FAMILY MEMBER	Identify Primary Follow up Physician/Primary Care Provider ❒_____ ❒NONE Is Primary Follow Up aware of this referral? ❒YES ❒NO

FAMILY / NEXT OF KIN / EMERGENCY CONTACT INFORMATION

NAME _____ ADDRESS _____

RELATIONSHIP _____ _____

PHONE _____ _____

REASON FOR REFERRAL

❒APPLICATION FOR ENROLMENT ❒OTHER _____

SYMPTOM PROFILE

DESCRIPTION	DATE OF ONSET
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

*****Shaded fields are mandatory. Referral will be processed only once these are all filled out.*****

INCLUSION CRITERIA (CHECK ALL THAT APPLY)	EXCLUSION CRITERIA (CHECK ALL THAT APPLY)
❒AGED 16 – 35 YEARS	❒PSYCHOSIS SECONDARY TO MOOD DISORDER
❒SYMPTOMS OF PSYCHOSIS OR EARLY PSYCHOSIS	❒PSYCHOSIS SECONDARY TO SUBSTANCE USE
❒SIX MONTHS OR LESS OF ANTIPSYCHOTIC TREATMENT	❒FORENSICS INVOLVEMENT
❒RESIDES WITHIN THE CHAMPLAIN DISTRICT	

MEDICAL HISTORY (IF APPLICABLE)

HAS PATIENT RECENTLY BEEN HOSPITALIZED OR ASSESSED BY A PSYCHIATRIST?

❒NO ❒YES, *please include history, available collateral and discharge summary or assessment report; referral will not be processed until these are received*

CURRENT MEDICATION(S)

MED	DOSE	DURATION

PLEASE ACKNOWLEDGE EACH STATEMENT BELOW BY INITIALING THE CORRESPONDING BOX

_____	For those patients enrolled in the program, multidisciplinary care is provided for a maximum period of three years based on the patient's medical and psychosocial needs. In the stable phase of illness, patients will be referred back to the community for ongoing care. Consultations may be provided for diagnostic purposes and/or community resources.
_____	Referring General Practitioners/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 *On Track*.
_____	Referring specialists will remain involved in care or make alternate care arrangements until confirmation of enrolment is received.

TO ENSURE THAT YOUR REFERRAL CAN BE PROCESSED IN A TIMELY MANNER, PLEASE CONFIRM THAT YOU HAVE	
For all referrals	If patient has recently been hospitalized or assessed by a psychiatrist
❒Completed all mandatory shaded fields	❒Attached discharge summary or assessment report OR
	❒Posted discharge summary or assessment report in vOacis

REFERRAL COMPLETED BY		
PRINT NAME	SIGNATURE	DATE

*****Shaded fields are mandatory. Referral will be processed only once these are all filled out.*****