EARLY PSYCHOSIS INTERVENTION PROGRAM
REFERRAL FORM

REFERRAL CRITERIA:

- Age 13 – 30 with suspected or first episode psychosis
- No previous appropriate treatment (Antipsychotic medication & case management)
- Please note that substance use does not disqualify from referral.
- Check all that apply:
  - Delusions
  - Hallucinations
  - Disorganized speech
  - Family history of psychotic disorder & serious psychosocial deterioration
  - Grossly disorganized behavior
  - Negative symptoms - e.g. flat affect or avolition
  - Other ___________________________________

DATE: ______________________ Referring Agency: __________________________

Referring Agency Contact Information: ____

CLIENT'S LEGAL NAME: ____

PREFERRED NAME & PRONOUNS______________________ GENDER: ___________

D.O.B: ___________________________ PHN: __________________________________

ADDRESS____

PHONE: _________________________ EMAIL: ________________________________

NEXT OF KIN: _________________________________ PHONE: ___________________

FAMILY PHYSICIAN & BILLING #:____

PRESENTING SYMPTOMS & CURRENT MEDICATIONS *(Please include consults & reports)*

EPI Intake Clinician will contact client to arrange initial assessment.

☐ **Fraser East**
Fax – 604-776-2121
Chilliwack, Abbotsford, Mission, Hope and Agassiz
Phone 1-866-870-7847

☐ **Fraser North**
Fax – 604-528-5470
Burnaby, Tricities, Maple Ridge, New Westminster
Phone 604-777-8386

☐ **Fraser South**
Fax – 604-538-4277
White Rock, Delta, Surrey, Langley
Phone 604-538-4278