



Early Psychosis Referral

Unit Record No: _____
 Name: _____
 Address: _____
 Date of Birth: _____ Sex: Male / Female

Place Identification Label here

Name:	D.O.B.:
Address:	Phone: Mobile:
Referring Worker and Agency:	G.P. Clinic : Phone :
Next of Kin Details: Relationship: Phone:	Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No Language: Special cultural considerations:

Has the young person given consent for this referral? Yes No (Attach copy)
Are family/carers aware of referral? Yes No

Has this person been treated by Mental Health Services in the past? Yes No
 If yes please give details: *(reason for treatment/who by/when/how long for/what medication used)*

Reason for Current Referral:

Please tick the box if any of the following are present:

<p>Changes in behaviours:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> Appetite changes <input type="checkbox"/> Withdrawn <input type="checkbox"/> Isolating <input type="checkbox"/> Erratic behaviour <input type="checkbox"/> Increase in risk taking behaviour <input type="checkbox"/> Suspicious/ paranoid <p>Changes in mood:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Irritable <input type="checkbox"/> Mood Swings <input type="checkbox"/> Elevated/ manic <input type="checkbox"/> Low motivation <p>Deterioration in functioning:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Deterioration in Self care <input type="checkbox"/> Problems with school/work <input type="checkbox"/> Deterioration in relationships <p>Perceptual disturbances:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Seen, tasted, felt, smelt or heard things that aren't there. <p>Explain:</p>	<p>Unusual thought content</p> <ul style="list-style-type: none"> <input type="checkbox"/> Have special powers or they are someone special <input type="checkbox"/> Involved somehow in a conspiracy <input type="checkbox"/> Special meanings from the environment intended for them <input type="checkbox"/> Being controlled by an external source <input type="checkbox"/> Thoughts removed / inserted from their head or broadcasted from <input type="checkbox"/> Other odd beliefs : <p>Changes in presentation:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Strange mannerisms or posturing <input type="checkbox"/> Easily distractible <input type="checkbox"/> Decreasing concentration <input type="checkbox"/> Disorganised speech <input type="checkbox"/> Speech is hard to follow and is pressured <input type="checkbox"/> Emotionally withdrawn <input type="checkbox"/> Heightened emotional tone <input type="checkbox"/> Restricted range of expressiveness in face, voice and gestures <input type="checkbox"/> Unable to answer questions because of being perplexed or thought blocked <p>Any other changes/symptoms?:</p>
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When did the above symptoms start, how frequently do they occur and how long do they last?
How does substance use affect symptoms? What impact does the symptoms have on the young person?



Jan-09

Patient Name: _____ UR Number: _____

Please include any relevant information in the following areas:

Recent Stresses:

Past trauma:

Family History of Mental Illness:

Substance Use History: *(substance/amount/route/frequency/duration) If ASSIST completed include results.*

Relevant Medical History, Co-morbid mental illness and Current Prescribed Medications if known:

Current Risks: *(Self-harm/suicide/violence/harm to others /homelessness/forensic/ vulnerability)*

Protective Factors: *(Supports/personal strengths/insight/employment/education/ interests)*

Current Needs and Any Existing Plans:

Referrer's Name: _____ **Signature:** _____

Agency: _____ **Date:** ____/____/____

Hume REPS clinician to complete:

Date received: ____/____/____

By whom: _____

Action taken: