Vancouver Early Psychosis Intervention (EPI)
#333-2750 East Hastings Street
Vancouver, B.C., V5K 1Z9
Phone: 604-675-3875
Fax: 604-675-3894
www.earlypsychosis.ca

EPI Vancouver Webpage.docx

REFERRAL FORM		
Name **PARIS ID:**		**Referral Date**
Address	**City**	**Postal Code**
Phone – Home	**Cell**	**Email**
DOB (mm/dd/yyyy)	**Gender**	**MSP PHN** ☐ **Active?**
Emergency Contact **Phone**	**Relationship**	**Out of province health number if applicable** ☐ **Active?**
Family Doctor	**Phone**	☐ **No Family Doctor**
Language	**Ethnicity**	
Referring Physician and MSP#:		
If not a physician: Referral Source Phone **Referral Source Agency and Role:**		
Involved Professionals: ☐ School/SACY Counsellor: ☐ MCFD Social Worker: ☐ Child & Youth Special Needs (CYNS)/Social Worker Assistant (AST): ☐ Probation Officer:		
Diagnoses (DSM-V):		

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Psychotic symptoms: (Give specific examples; hallucinations, delusions, if paranoid, describe its manifestation; thought process, assess sleep, appetite, unusual behavior, isolating, increase or decrease in activity; any significant change from usual functioning & behavior, etc.)
Psychiatric History: (list all hospitalizations: where/dates/discharge dx & meds; details of prior treatment; on set of primary psychosis, duration of previous treatment for psychosis). **Attach all hospital discharge and consult reports.**
Current Medication(s) Dosage: (if on depot when next due) ☐ Plan G in place ☐ Special Authority acquired if necessary ☐ Documentation of AIMS/EPS examination
Medical History (including history of side effects):
Substance Use History:
Personal Strengths/Protective Factors:
Family History: (list all family members/ages; living arrangements; psychiatric family history)
Education History: (Level of Education, schools)
Vocational History: (employment stats, income source)

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Diagnosed Intellectual Disability: (If yes, give details)
Developmental History (give details)
Suspected/Diagnosed Autism Spectrum Disorder (i.e. Asperger's Syndrome, PDD-NOS)**:** ☐**Yes** ☐**No**
Suspected/Reported Trauma/Dissociative Disorder: (If yes, give details)
Criminal Behavior/Forensic Involvement; Court Dates; Charges Pending:
Risk to Self: (i.e. suicide/self-harm)
Risk to Others: (i.e. weapons, aggressive, history of assault/violence, sexual violence)
Extended Leave If yes, ensure forms are finalized and complete: ☐ Form 4 (x2) ☐ Form 6 ☐ Form 13 ☐ Form 15 ☐ Form 16 ☐ Form 20 ☐ review panel documentation
Progress in Hospital (Describe treatment provided, medication trials, functional changes, current psychiatric symptomology, cognitive changes, family dynamics)
Discharge Plan (school, community resources, professionals involved in care, such as social workers, CLBC, etc.)

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Must attach the following information in order for referral (all ages) to be processed:

- ☐ Psychiatric Consultation Notes
- ☐ Psychological Reports (i.e. Psycho-Education Assessment) (if completed)
- ☐ Neurology Report (if completed)
- ☐ Discharge Summary Profile
- ☐ MAR Sheet (medication records)
- ☐ Plan G in place
- ☐ Special Authority acquired if necessary
- ☐ Documentation of AIMS/EPS examination
- ☐ Recent Lab Work (including Cholesterol, Blood Sugar Levels, Prolactin)
- ☐ Metabolic Assessment (including height, weight, blood pressure, waist circumference and BMI)
- ☐ Current safety plans for self and/or others

Extended Leave If yes, ensure forms are finalized and completed:

☐ Form 4 (x2) ☐ Form 6 ☐ Form 13 ☐ Form 15 ☐ Form 16 ☐ Form 20 ☐ documentation related to review panel

For child & youth less than 19 years of age, ALSO include the following:

- ☐ Can child/youth attend **in-person** initial assessment/consultation, if appropriate?
- ☐ Can **parents** attend initial assessment/consultation with child/youth, if appropriate?
- ☐ For BC Children's Hospital referral – will **LINK** be set up for bridging, if appropriate?