Coastal Early Psychosis Intervention (EPI) Program
North Shore Referral Package

Referral Criteria:

- Serves clients 13 – 30 years old at time of referral
- Currently living on the North Shore: North Vancouver, West Vancouver or Bowen Island. Referrals from other coastal communities (Squamish, Whistler, Pemberton, Bella Bella, Bella Coola, Sunshine Coast, and Powell River) have a different internal referral form. Please contact your local Mental Health and Substance Use service to discuss this possibility.
- Experiencing first episode psychosis OR
- Are in the first 2 years of their psychotic illness and have not received appropriate treatment (untreated) or have received treatment (treated) for under 1 year.

Referrals and additional information can be faxed or emailed to EPI Coastal
Fax number: 604-983-6075 Email: EPICoastal@vch.ca

Each referral is reviewed on a case-by-case basis. An EPI clinician will contact you to discuss the referral once it is reviewed by the team.

For questions/inquiries, contact EPI Coastal at 604-984-5000 or Email at EPICoastal@vch.ca

Mon-Fri 8:30-4:30

Coastal Early Psychosis Intervention
Phone: 604-984-5000
Fax: 604-983-6075 **Email:** EPICoastal@vch.ca

Paris ID (if known): _____

Date Received: _____

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

REFERRAL FORM

THIS IS NOT AN EMERGENCY SERVICE. CALL 911 FOR EMERGENCY RESPONSE.

Client Name: _____ **PHN:** _____
Last Name First Name Preferred Name
PHN Active? ☐ *Yes* ☐ *No*

Address: _____ **DOB (mm/dd/yyyy):** _____

**Please Note: Must live on the North Shore – other coastal communities (Sea to Sky, Bella Bella, Bella Coola, Sunshine Coast, and Powell River) have a different Internal referral form.*

Current Living Situation (i.e. with family, roommates, independently): _____

Gender: _____ **Sex Assigned at Birth**: _____ **Pronouns Used:** _____

Primary Phone: _____ **Other Phone:** _____
Can message be left? ☐ *Yes* ☐ *No* *Can message be left?* ☐ *Yes* ☐ *No*

Primary Email Address: _____ **Is the client aware of this referral?** ☐ *Yes* ☐ *No* ☐ *N/A*

Ethnicity: _____ **Client Identifies as Indigenous:** ☐ *Yes* ☐ *No* ☐ *Prefer not to answer*

Preferred Language: _____ **Interpreter Needed?** ☐ *Yes* ☐ *No*

Who to Contact to Book Appointment if not Client: Name (first/last): _____ **Phone:** _____

Emergency Contact (e.g. parent, Substitute Decision Maker): _____ **Is this person aware of referral?** ☐ *Yes* ☐ *No*

Out of Province Health Number (If applicable): _____ **Is this number active?** ☐ *Yes* ☐ *No*

Referral Source: *(name, agency, address, phone)*	**Primary Medical Care Provider:** *(e.g. family physician, nurse practitioner - name, address, phone, fax, MSP billing #)* ☐ *No Family Doctor/Primary Care provider*
Diagnoses (DSM-5):	**Diagnosed by:** _____ **Estimated Onset of symptoms of Psychosis:** **Estimated Duration of untreated Psychosis:**

Symptoms of Psychosis: *(Give specifics re: hallucinations, delusions, if paranoid, describe manifestation; thought process; sleep, appetite, unusual behavior, isolating, increase/decrease in activity; any significant change from usual functioning/behaviour, etc)*

Substance Use (if applicable): ☐ Not Applicable
Current **(C)** or Past **(P)**

Cocaine/Crack: ☐ C ☐ P
Alcohol: ☐ C ☐ P
Benzodiazepines: ☐ C ☐ P
Nicotine: ☐ C ☐ P
Hallucinogens: ☐ C ☐ P
Cannabis: ☐ C ☐ P
Ecstasy/Club: ☐ C ☐ P
Stimulants/CrystalMeth: ☐ C ☐ P
Other:_____

Describe *(e.g. type, frequency, amount, what route):*

Medical Conditions *(including allergies and history of side effects):*

Personal Strengths/Protective Factors:

Risk of Harm to Self/Others: ☐ Yes ☐ No
(e.g. self-harm, suicidal/homicidal ideation, escalating violence towards others, criminal or legal involvement, any risk to staff)
Describe:

Educational History *(level of education):*

Vocational History *(employment status, income source)*:

Criminal Behaviour/Forensic Involvement *(court dates, charges pending):*

Developmental History *(i.e. developmental milestones, temperament as a child)*

Diagnosed Intellectual Disability: ☐ Yes ☐ No
If yes, provide details:

Suspected/Diagnosed Autism Spectrum Disorder: ☐ Yes ☐ No
If yes, provide details:

Family History *(list family members/ages; living arrangements, psychiatric family history):*

Suspected/Diagnosed Trauma/Dissociative Disorder:
If yes, provide details: ☐ Yes ☐ No

Other Involved Professionals (i.e. MCFD, SW, School Counsellor, Probation Officer, etc.):

Current Medications (or attach MAR): **Please include Opioid replacement therapy if applicable*

If applicable, date of next injection medication:_____

☐ Plan G in place ☐ Special Authority acquired if necessary ☐ Documentation of AIMS/EPS examination if applicable

Psychiatric History (list all hospitalizations: where/dates/discharge dx & meds; details of prior treatment; onset of primary psychosis, duration of previous treatment for psychosis). **Attach all hospital discharge and consult reports.**

*****IF CLIENT IS CURRENTLY IN HOSPITAL PLEASE COMPLETE THE FOLLOWING PAGE OF REFERRAL*****

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Progress in Hospital (Describe treatment provided, medication trials, functional changes, current psychiatric symptomology, cognitive changes, family dynamics):

Discharge Plan (school, community resources, professionals involved, such as social workers, CLBC, etc):

All referrals coming from hospital require the following information:

- ☐ **Psychiatric Consultation Notes**
- ☐ **Psychological Reports (i.e. Psycho-Education Assessment) (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**

Please Note: A Doctor-to-Doctor conversation is required prior to an individual being accepted into care on Extended Leave

Early Psychosis Intervention are non-emergency outpatient specialty services that work in partnership with referring partners (e.g. family doctors; school counsellors; social workers, etc).
Incomplete referral forms may be sent back to the referral source for completion.
By signing here, I acknowledge the ongoing nature of this collaborative approach to providing services for this client

Referral Source Signature:_____ **Print Name**:_____ **Date:**_____