EASA PROGRAM - REFERRAL FORM

County of Residence: Agency Name: Prime#:

Staff Name: Client ID #:

Client Name: Referral Date:

Referral Year: ○ QTR1-Jan-Mar ○ QTR2-Apr-Jun ○ QTR3-Jul-Sept ○ QTR4-Oct-Dec

Client Demographics

Date of Birth: ☐ Unknown (age if DOB is unknown)

Client Identified Race: (check all that apply)

- ☐ Alaska Native
- ☐ American Indian
- ☐ Black or African American
- ☐ White
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Single Race (specify)
- ☐ Unknown

Client Identified Ethnicity: (check all that apply)

- ☐ Not of Hispanic Origin
- ☐ Mexican
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other Specific Hispanic (specify)
- ☐ Hispanic – Specific Origin not Specified
- ☐ Unknown

Client identified Gender Identity:

- ○ Female
- ○ Male
- ○ Gender Non-conforming
- ○ Genderqueer
- ○ Gender Fluid
- ○ Non-binary
- ○ A gender identity no represented here (specify)
- ○ Unknown

Client identifies as transgender?

- ○ Yes
- ○ No
- ○ Unknown

Living situation on referral date:

- Transient/Homeless (no permanent address)
- Foster Home
- Residential Facility
- Jail
- Prison
- Supported Housing
- Alcohol and Drug Free Housing
- Private Residence (lives alone)
- Private Residence (with relative)
- Private Residence (with non-relative)
- Other (specify)
- Unknown

Primary Language:

- English
- Spanish
- Other (specify)
- Unknown

Referral Information and Screening Process

Who was the referral to the EASA program completed with?

- Medical Provider
- School, Staff or Liason
- Outpatient Mental Health Provider (same agency as EASA)
- Outpatient Mental Health Provider (different agency than EASA)
- Crisis System / Emergency Department staff
- Psychiatric Hospital staff
- Clergy
- Justice System staff
- Residential Treatment staff
- Social Services Provider staff
- Vocational Rehabilitation staff
- Family Member of Client
- Client
- Other (specify)
- Unknown

If referral was completed with family member or client
How did the client/family learn about the EASA program/ Who did they learn about the program from?

- Medical Provider
- School, Staff or Liason
- Outpatient Mental Health Provider (same agency as EASA)

- Outpatient Mental Health Provider (different agency than EASA)
- Crisis System / Emergency Department
- Psychiatric Hospital
- Family, Friend or other Natural Support Person had prior knowledge of EASA
- Advocacy Group
- Clergy
- Information and Referral Line or Crisis Line
- Internet search led to EASA website
- Justice System
- Media
- Public Presentation
- Residential Treatment
- Social Services Provider
- Vocational Rehabilitation
- Other (specify)
- Unknown

Is this the referent's (the person who the referral was completed with) first referral to EASA?
- Yes
- No
- Unknown

Screening process

Did staff meet with client in community or clients preferred setting as part of the screening/engagement process?
- Yes
- No
- Unknown

Were any client natural supports (family or friends) involved in the screening?
- Yes
- No
- Unknown

Referral Decision

Decision Date: Person Making Decision:

☐ Screened In (check and select the choice below that contributed most to the acceptance)

- ○ First episode psychosis, onset of DSM 5 psychotic disorder within 12 months (number of months , weeks , days)
- ○ First episode psychosis, onset of DSM 5 psychotic disorder greater than 12 months by exception (number of months)
- ○ Symptoms consistent with Psychosis Risk Syndrome
- ○ Further Assessment needed to assess appropriateness
- ○ Family history with decline
- ○ Other Reason (specify)

☐ Screened Out (check and select the choice below that contributed most to the rejection)

- ○ No Symptoms of Psychosis
- ○ IQ under 70
- ○ Age
- ○ Onset of DSM 5 psychotic disorder greater than 12 months (number of months)
- ○ Client/Family Declined
- ○ Left area before engaging
- ○ Differential diagnoses not consistent with schizophreniform, or affective psychosis (specify DSM 5 diagnostic code(s) (ICD-10 , , , ,)
- ○ Long-term incarceration
- ○ Unable to assess/engage referred person (place details in notes)
- ○ Other Reason (specify)

If the client was screened out, to what alternative services was the client directed?

- ○ Substance Use Treatment
- ○ Mental Health Provider (specify)
- ○ EASA program in different county
- ○ No appropriate provider available (specify)
- ○ Unable to assess/engage referred person, no connection made
- ○ Client/Family Declined

Notes: