

# Early Assessment and Support Alliance (EASA)

## Marion County Referral Form

The following are guidelines to decide whom to refer to EASA. Clients that are a good fit for EASA have symptoms of psychosis consistent with schizophrenia related conditions. Acceptance into the program will be based on further screening and assessment. Referents should explain to individuals that they are being referred for an assessment to determine whether EASA is a good fit for them and should continue to follow up with individuals referred until a decision regarding EASA is made.

### **Must meet all of the following**

- Resides in Marion County
- Age 12-25
- The person has an IQ of 70 or above and does not have a previous diagnosis of a pervasive developmental disorder (e.g. an autism spectrum disorder)
- The person has not received treatment for psychosis in the past year
- Psychotic symptoms are not known to be caused by the effects of substance abuse or medical condition
- The person has experienced a significant decline in either academic, vocational, social, or personal (sleep, hygiene) functioning

### **And must meet *either* item below**

- The individual has experienced significant worsening or new symptoms in one or more of the following areas *in the last 12 months*:
  - \*Thought disorganization as evidenced by disorganized speech and or/ writing. (Examples: confused conversations, not making sense, never getting to a point, unintelligible)
  - \* Behaviors, speech, or beliefs are uncharacteristic and/or bizarre
  - \* Complains of hearing voices or sounds that others do not hear
  - \* The individual feels that other people are putting thoughts in their head, stealing their thoughts, believes others can read their mind (or vice versa), and/or hear their own thoughts out loud
  - \* Episodes of depersonalization (Example: They believe that they do not exist or that their surroundings are not real)
  - \* Heightened sensitivities (lights, sounds etc.) and/or is experiencing visual distortions
  - \* Increased fear, anxiety or paranoia for no apparent reason or for an unfounded reason
- ~OR~**
- Family history of a 1st degree relative (sibling or parent) with a major psychotic disorder

*If the individual you are referring is in an immediate danger to self or others you will need to refer directly to the local crisis system. The crisis system will refer to EASA when the crisis resolves. To make a referral, call or fax a referral form to the EASA intake screener. Include all relevant assessments and releases of information.*

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**Marion County Intake Coordinator: Phone: 503-576-4690 Fax: 503-584-4837**  
**For general program inquiries, contact EASA Clinical Supervisor Robin Sischo at 503-361-2711**

# EASA PROGRAM - REFERRAL FORM

Referral Date: \_\_\_\_\_

## Individual being referred

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Gender: FEMALE MALE OTHER

Date of Birth: \_\_\_\_\_ Primary language(s): \_\_\_\_\_

## Ethnicity

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Asian                   | <input type="checkbox"/> Other Hispanic                     |
| <input type="checkbox"/> Native American        | <input type="checkbox"/> Hispanic (Mexican)      | <input type="checkbox"/> Southeast Asian                    |
| <input type="checkbox"/> Caucasian/White        | <input type="checkbox"/> Hispanic (Puerto Rican) | <input type="checkbox"/> Alaskan Native                     |
| <input type="checkbox"/> Other: _____           | <input type="checkbox"/> Hispanic (Cuban)        | <input type="checkbox"/> Hawaiian or Other Pacific Islander |

## How the client was referred

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Crisis System or ED               | <input type="checkbox"/> Social Services Provider | <input type="checkbox"/> Public presentation            |
| <input type="checkbox"/> Outpatient Mental Health Provider | <input type="checkbox"/> School                   | <input type="checkbox"/> Media                          |
| <input type="checkbox"/> Psychiatric Hospital              | <input type="checkbox"/> Word of mouth            | <input type="checkbox"/> Website                        |
| <input type="checkbox"/> Medical Provider                  | <input type="checkbox"/> Local advocacy group     | <input type="checkbox"/> Law Enforcement or Corrections |
| <input type="checkbox"/> Other: _____                      |   |   |

## Referent contact information: (Person making the referral)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

\_\_\_\_\_ Relationship to person being referred: \_\_\_\_\_

## Who should EASA contact regarding engaging the referred individual

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

**List of additional Contacts: (family, guardians, treatment providers, and other supports)**

1) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Contact this individual: YES NO

2) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Contact this individual: YES NO

**Reason for Referral (specific symptoms, onset, frequency, severity, and duration)**

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**Cultural considerations that may impact screening and/or assessment**

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**Person's knowledge about and/or reaction to this referral**

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**Family history of psychotic illness**

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**Other services received prior to referral**

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**Living Situation at Referral**

<input type="checkbox"/> With Family	<input type="checkbox"/> Spouse	<input type="checkbox"/> Group Home	<input type="checkbox"/> Hospital-Medical
<input type="checkbox"/> Alone	<input type="checkbox"/> Foster Parents	<input type="checkbox"/> Dorm	<input type="checkbox"/> Hospital-Psychiatric
<input type="checkbox"/> Homeless	<input type="checkbox"/> Friends	<input type="checkbox"/> Juv. Detention	<input type="checkbox"/> Residential Program
<input type="checkbox"/> Other: _____			

**Educational Involvement at Referral**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Not in school-Wants to go   | <input type="checkbox"/> Part-time school | <input type="checkbox"/> Full-time school |
| <input type="checkbox"/> Not in school-Does not want | <input type="checkbox"/> Part-time trade  | <input type="checkbox"/> Full-time trade  |
| <input type="checkbox"/> Part-time GED               | <input type="checkbox"/> Completed school |   |

Last grade completed: \_\_\_\_\_ (count each year after high school as a grade)

**Employment at Referral**

- |  |  |
|--|--|
| <input type="checkbox"/> Not working – Does not want | <input type="checkbox"/> Working Part-time |
| <input type="checkbox"/> Not working – Wants to work | <input type="checkbox"/> Working Full-time |
| <input type="checkbox"/> Not working – Seeking work  | <input type="checkbox"/> Not working age   |

**Employment type at Referral**

- |                                      |
|--------------------------------------|
| <input type="checkbox"/> Competitive |
| <input type="checkbox"/> Sheltered   |
| <input type="checkbox"/> Volunteer   |

**Insurance Status at admit (check all that apply)**

- |  |                              |                                   |
|--|------------------------------|-----------------------------------|
| <input type="checkbox"/> None  | <input type="checkbox"/> OHP | <input type="checkbox"/> Medicare |
| <input type="checkbox"/> Private: _____<br>Name of Insurance Company |                              |                                   |

**Referent Information**

**Note:** The information *below* is voluntary and won't affect the outcome of this referral. We use the information below to improve our outreach efforts.

**Is this your first referral to EASA?**                      YES                      NO

**How did you hear about EASA**

- |   |   |                                  |
|---|---|----------------------------------|
| <input type="checkbox"/> Crisis System or ED    | <input type="checkbox"/> Social Services Provider | <input type="checkbox"/> Media   |
| <input type="checkbox"/> Outpatient MH Provider | <input type="checkbox"/> Law Enforcement          | <input type="checkbox"/> Website |
| <input type="checkbox"/> Psychiatric Hospital   | <input type="checkbox"/> Word of mouth            | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Medical Provider       | <input type="checkbox"/> Local Advocacy Group     |                                  |
| <input type="checkbox"/> School                 | <input type="checkbox"/> Public Presentation      |                                  |

**Please check the category that best describes yourself**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> School professional       | <input type="checkbox"/> Multicultural leader | <input type="checkbox"/> Law Enforcement       |
| <input type="checkbox"/> Youth Worker              | <input type="checkbox"/> Member of Clergy     | <input type="checkbox"/> Middle School Student |
| <input type="checkbox"/> Medical Professional      | <input type="checkbox"/> Member of the Media  | <input type="checkbox"/> High School Student   |
| <input type="checkbox"/> MH Professional           | <input type="checkbox"/> Employer             | <input type="checkbox"/> College Student       |
| <input type="checkbox"/> Substance Abuse Therapist | <input type="checkbox"/> Parent               | <input type="checkbox"/> Young Adult (18-25)   |
| <input type="checkbox"/> Community Group Member    |   |  |

# Frequently Asked Questions

\*For information on EASA's services and who to contact for referrals please go to our website:

[www.easacommunity.org](http://www.easacommunity.org)

\*For information on other the EASA programs visit:

<http://www.oregon.gov/DHS/mentalhealth/services/easa/main.shtml>

\*You may also call 1-888-327-8817

## **What happens when I make a referral?**

The EASA Team Lead for the individual's county of residence will collect more information from you about the person's symptoms, history, and situation. At that point, the Team Lead may want to complete an initial assessment with the individual and/or family. EASA attempts to make sure that people are receiving the most appropriate treatment by doing a careful upfront screening and initial differential diagnosis process. EASA asks that if you are currently working with someone who is referred to EASA, you maintain your involvement until EASA has formally accepted the person into ongoing services. If it is determined that EASA is not a good fit for the individual, we will support the individual, family, and/or referent to identify resources that are more likely to be helpful.

## **When might EASA not accept someone who seems to fit the referral guidelines?**

EASA is a specialty program focusing on individuals whose symptoms are consistent with the early stages of schizophrenia and related conditions. A number of other conditions, such as ADHD, major depression, severe anxiety, or post-traumatic stress disorder can have symptoms similar to the early stages of psychotic illness, but require a different form of treatment and support. EASA tries to ensure that the clinical services the person receives are appropriate to that person, and will not accept individuals whose treatment needs are different than EASA's primary focus.

## **How can I help make the referral go more smoothly?**

It is not uncommon that the EASA Team Lead will want to review medical and /or mental health documentation regarding the client's symptoms and current status. If you have access to such documentation, providing that to EASA directly with signed releases of information will move the process along more quickly. It is not necessary to have such documentation to make a referral, though it is important to fill out the referral form as completely as possible.

## **Does EASA accept people who are actively using illegal drugs?**

EASA recognizes that young people with the conditions we serve use illegal drugs and will not be automatically screened out as a result. However, if as part of the initial screening process, EASA learns that the drug use is the primary contributor to the current symptoms, the individual will be screened out and referred to more appropriate services.

### **Does EASA ever accept individuals over the age of 25 or under the age of 12?**

Yes, EASA will consider accepting individuals into the program outside our age criteria if it is determined in the screening that all other criteria are met. However, EASA's focus is on serving the developmental needs of individuals in the transitional age range. To meet the needs of our current clients EASA will not accept individuals significantly outside of our age criteria.

### **What if the person I want to refer is appropriate for EASA but does not want help?**

EASA can be very flexible in working with the individual's support system to provide them with information and strategies for engaging the individual. EASA can also meet the client in an environment that is comfortable for them, and engage them in a way that is not entirely focused on mental health treatment.

### **Will EASA accept people who are acutely psychotic?**

Yes. However, if EASA feels the individual is at risk of harming oneself or others we may ask and/or assist in the individual receiving hospital care. If the client is appropriate for services we will stay involved with the individual and the family throughout this episode.

### **Will EASA accept people who have been ill for longer than 12 months?**

We recognize that it can take years for a serious mental illness to be diagnosed, and will accept individuals who have had a lengthy "prodromal period" prior to coming to the attention of mental health professionals. However, if an individual carries a diagnosis of a schizophrenia related illness for more than a year, they are likely not appropriate for EASA.

### **Will EASA accept someone who is developmentally delayed/disabled and experiencing psychosis?**

We normally do not, as this individual would have special needs beyond EASA's treatment parameters, and may be better served by the DD system.

### **What does it cost to be served by EASA? Does EASA take insurance?**

EASA will bill insurance, whether OHP or private, for all applicable services. Our mission is to serve eligible individuals regardless of ability to pay, though we would ask people to do their best to pay for services rendered so that EASA can sustain its services into the future.

### **How long does it take someone to be accepted into EASA?**

Once a referral form is received, the Intake Coordinator will typically contact the referent within two business days to begin the screening process. From there, the process can take anywhere from 1 day to several weeks depending on the information available, the acuity of the individual, and the availability of the individual and their support system. EASA will keep the referent informed of their progress throughout the screening process. You will be notified directly when the client is accepted. If the client is screened out, you will be notified by phone and/or letter.