EASA PROGRAM – REFERRAL

(For Multiple Referrals: complete only one referral form (use first date of referral) UNLESS the person is referred but not accepted and then after another referral is screened in) ***Also remember to Complete or Update the Participant Details Event***

AGENCY IDENTIFIERS – *Entered at 'Participant' level – please update any 'Unknown' or 'Missing' values*

Client (Agency) ID # _____ **Prime # (OHP ID)** _____

County of Residence _____ **Agency Name** _____

HIPAA IDENTIFIERS – *Entered at 'Participant' level – please update any 'Unknown' or 'Missing' values*

First Name _____ **Middle Name** _____ **Last Name** _____

Date of Birth __ __ / __ __ / __ __ ☐ Check if Date of Birth is Unknown

FORM DETAILS

Year |_|_|_|_| **Quarter** ○ 1 Jan-Mar ○ 2 Apr-Jun ○ 3 Jul-Sep ○ 4 Oct-Dec

Referral Date __ __ / __ __ / __ __ **Completed Form Staff Name** _____

DEMOGRAPHICS – *Entered at 'Participant' level – please update any 'Unknown' or 'Missing' values*

Race *(check all that apply)*

- ☐ Alaska Native
- ☐ American Indian
- ☐ Black of African American
- ☐ White
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Race
- ☐ Unknown

Ethnicity *(check all that apply)*

- ☐ Not of Hispanic Origin
- ☐ Mexican
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other Specific Hispanic, specify _____
- ☐ Hispanic – Specific Origin Not Specified
- ☐ Unknown

Gender at Birth

- ○ Female
- ○ Male
- ○ Non-binary

Gender Identity *(client identified)*

- ○ Cisgender (gender identity that is consistent with the sex they were assigned at birth)
- ○ Transgender (gender identity that does not match the sex they were assigned at birth)
- ○ Non-binary/ Genderqueer (gender identity that does not identify strictly as a boy or a girl)
- ○ Agender/ Neutrosis (gender identity that does not identify with any gender)
- ○ Gender fluid (gender identity varies over time)
- ○ A gender identity not represented above
- ○ Unknown

Age at Referral _____

CLIENT IDENTIFIERS

Full Name _____ **DOB** __ __ / __ __ / __ __ **Agency ID** _____

SCREENING

Who was the referral to the EASA program completed with?
(check all that apply)

- ☐ Medical Provider
- ☐ School Staff or Liaison
- ☐ Outpatient Mental Health Provider (same agency as EASA)
- ☐ Outpatient Mental Health Provider (different agency as EASA)
- ☐ Crisis System / Emergency Dept. Staff
- ☐ Psychiatric Hospital Staff
- ☐ Clergy
- ☐ Justice System Staff
- ☐ Residential Treatment Staff
- ☐ Social Services Provider Staff
- ☐ Vocational Rehabilitation Staff
- ☐ Family Member of Client * } Answer question to right
- ☐ Client * } Answer question to right
- ☐ Other, specify _____
- ☐ Unknown

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

- ○ Medical Provider
- ○ School Staff or Liaison
- ○ Outpatient Mental Health Provider (same agency as EASA)
- ○ Outpatient Mental Health Provider (different agency as EASA)
- ○ Crisis System / Emergency Department Staff
- ○ Psychiatric Hospital Staff
- ○ Clergy
- ○ Justice System Staff
- ○ Residential Treatment Staff
- ○ Social Services Provider Staff
- ○ Vocational Rehabilitation Staff
- ○ Other, specify _____
- ○ Unknown

Did staff meet with client in community or clients preferred setting as part of the screening/ engagement process?

- ○ Yes
- ○ No
- ○ Unknown

Is this the referent's (the person who the referral was completed with) first referral to EASA?

- ○ Yes
- ○ No
- ○ Unknown

Were any client natural supports (family or friends) involved in the screening?

- ○ Yes
- ○ No
- ○ Unknown

LIVING SITUATION, SUPPORT, LEGAL & MISC.

Living Situation on Referral Date *(check all that apply)*

- ☐ Transient/ Homeless
- ☐ 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

CLIENT IDENTIFIERS

Full Name _____ **DOB** __ __ / __ __ / __ __ **Agency ID** _____

REFERRAL DECISION – *update Current Status field with referral decision*

Decision Date __ __ / __ __ / __ __ **Person Making Decision** _____

Decision

- ○ Screened In ➔ **Select the Choice that Contributed Most to 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 (Number of Months _____)
  - ○ Symptoms Consistent With Psychosis Risk Syndrome
  - ○ Further Assessment Needed to Assess Appropriateness
  - ○ Family History With Decline
  - ○ Other Reason, specify _____

  UPDATE Status to Screened Out if the client did not engage AND did not complete an Intake Visit.
- ○ Screened Out ➔ **Select the Choice that Contributed Most to 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 ICD-10 Diagnostic Code(s)):

    _____ _____ _____ _____ _____
  - ○ Long-term Incarceration
  - ○ Unable to Assess/Engage Referred Person (Place Details In Notes) –*Include Clients that Withdrew Prior to Completing An Intake But Otherwise Screened In*
  - ○ Other Reason, specify _____

Notes _____

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