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***

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

Client (Agency) ID # _____ **Prime # (OHP/ Medicaid ID)** _____ **Client Initials** __ __ __

County of Residence _____ **Agency Name** _____

Participant's Current Status *Only applicable options displayed below*

- ○ In Screening Process (Referral decision not made)
- ○ Screened Out at Referral
- ○ Screened In at Referral

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

First Name _____ **Nick 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 in 'Participant Details - Demographics' form – please update any 'Unknown' or 'Missing'*

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

Age at Referral

_____

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

CLIENT IDENTIFIERS

Client (Agency) ID # _____ **Prime # (OHP/ Medicaid ID)** _____ **Client Initials** __ __ __

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 *
- ☐ 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

Client (Agency) ID # _____ **Prime # (OHP/ Medicaid ID)** _____ **Client Initials** __ __ __

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

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

Does the participant have an IQ under 70?

- ○ Yes
- ○ No
- ○ Uncertain, Assessment Needed
- ○ Unknown

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
- ○ 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 _____

If the client was screened out, to what alternative services was the client directed?
(check all that apply)

- ☐ Substance Use Treatment
- ☐ Mental Health Provider
- ☐ EASA program in different county
- ☐ Client/ Family Declined
- ☐ Unable to assess/engage referred Person, no connection made
- ☐ Client/ Family Declined

Notes _____

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