EASA PROGRAM – REFERRAL

(Participants who have been screened in do not need to go through the referral/screening process again. Screened-in participants will always be considered eligible for the program) ***Also remember to Complete or Update the Participant Details Event***

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

Full name _____ **DOB** ___/___/___

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

Has this person ever been referred or enrolled in EASA (including in a county/agency)?

- ☐ Yes
- ☐ No
- ☐ Unknown

FORM DETAILS

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

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

SCREENING

Who referred this client to EASA?
(check only one)

- ☐ Outpatient Mental Health Provider (within the same agency as this EASA program)
- ☐ Outpatient Mental Health Provider (outside this EASA program)
- ☐ Psychiatric Hospital
- ☐ Residential Treatment or Group Home
- ☐ Crisis System (ER staff or ED provider)
- ☐ EASA Center for Excellence Online PQ-B
- ☐ School staff or Liaison (teacher, school counselor, etc)
- ☐ Primary Care Provider
- ☐ Health insurance care coordinator or care manager
- ☐ Justice System (Probation officer, police, etc)
- ☐ Social Services Provider (DHS caseworker, IDD staff, etc)
- ☐ Family member of client* } **Answer question to right**
- ☐ Client (self-referred)* }
- ☐ Transfer from another EASA agency (participant moved)
- ☐ Other, specify _____

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

- ☐ Outpatient Mental Health Provider (within the same agency as this EASA program)
- ☐ Outpatient Mental Health Provider (outside this EASA program)
- ☐ Psychiatric Hospital
- ☐ Residential Treatment or Group Home
- ☐ Crisis System (ER staff or ED provider)
- ☐ EASA Center for Excellence Online PQ-B
- ☐ School staff or Liaison (teacher, school counselor, etc)
- ☐ Primary Care Provider
- ☐ Health insurance care coordinator or care manager
- ☐ Justice System (Probation officer, police, etc)
- ☐ Social Services Provider (DHS caseworker, IDD staff, etc)
- ☐ Transfer from another EASA agency (participant moved)
- ☐ Other, specify _____

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

IDENTIFIERS

Full Name _____ **DOB** ___/____/____

LIVING SITUATION, SUPPORT, LEGAL & MISC.

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

- ☐ 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

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
- ○ First Episode Psychosis, Onset of DSM 5 Psychotic Disorder Greater Than 12
- ○ Symptoms Consistent With Psychosis Risk Syndrome
- ○ Further Assessment Needed to Assess Appropriateness
- ○ Family History With Decline
- ○ Transfer from another EASA agency
- ○ Other Reason, specify _____

○ 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
- ○ 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*
- ○ Referred to other EASA program, specify _____
- ○ Other Reason, specify _____

IDENTIFIERS

Full Name _____ **DOB** ___/____/____

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
- ☐ No appropriate provider available _____
- ☐ No services needed
- ☐ Unable to assess/engage referred Person, no connection made
- ☐ Client/ Family Declined

Notes _____

_____

_____