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** _____

READ Demographics *Entered in 'Participant Details- READ Demographics' – please update any 'Unknown' or 'Missing'. Not all questions here are asked in REDCap. Only the questions asked here are required to be entered into REDCap*

Was READ demographic information gathered via interview? ☐ Yes ☐ No

How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?

_____

Which of the following describes your racial or ethnic identity? Please check all that apply.

Hispanic and Latino/a/x
- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Other Hispanic or Latino/a/x

Native Hawaiian and Pacific Islander
- ☐ CHamoru (Chamorro)
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

White
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

American Indian and Alaska Native
- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

Black and African American
- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Other Black

Middle Eastern/North African
- ☐ Middle Eastern
- ☐ North African

Asian
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Other categories
- ☐ Other (please list) _____
- ☐ I don't know my racial or ethnic identity
- ☐ I decline to answer

Country of Origin (birth or citizenship)
- ○ US
- ○ Mexico
- ○ Other, specify _____
- ○ I don't know which country I was born in or my citizenship

Do you speak a language other than English at home?
- ○ Yes
- ○ No, only English

IDENTIFIERS

Full Name _____ **DOB** _____

REALD Demographics – *Entered in 'Participant Details- REALD Demographics' form – please update any 'Unknown' or 'Missing'*

1.Are you deaf or have serious difficulty hearing?
☐ No ☐ Yes *at what age___ ☐ Don't want to answer ☐ Don't know ☐ I don't understand what this is asking

2.Are you blind or do you have serious difficulty seeing even when wearing glasses?
☐ No ☐ Yes *at what age___ ☐ Don't want to answer ☐ Don't know ☐ I don't understand what this is asking

3.Do you have serious difficulty walking or climbing stairs?
☐ No ☐ Yes *at what age___ ☐ Don't want to answer ☐ Don't know

4.Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
☐ No ☐ Yes *at what age___ ☐ Don't want to answer ☐ Don't know

5.Do you have difficulty dressing or bathing?
☐ No ☐ Yes *at what age___ ☐ Don't want to answer ☐ Don't know

6.Using your usual or customary language, do you have serious difficulty communicating?
☐ No ☐ Yes *at what age___ ☐ Don't want to answer ☐ Don't know ☐ I don't understand what this is asking

Please stop now if you/the person is under age 15

7.Because of physical, mental, or emotional conditions, do you have serious difficulty doing errands alone, such as visiting a doctor's office or shopping?
☐ No ☐ Yes *at what age___ ☐ Don't want to answer ☐ Don't know

8.Do you have serious difficulty with mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations?
☐ No ☐ Yes *at what age___ ☐ Don't want to answer ☐ Don't know ☐ I don't understand what this is asking

Which of these most closely describes your gender identity?
☐ Cisgender (same as sex assigned at birth) ☐ Transgender ☐ Non-binary ☐ Agender or No gender
☐ Gender fluid ☐ Something else: _____ ☐ I don't understand this question ☐ Decline to answer

Sex assigned at birth:
☐ Male ☐ Female ☐ Intersex

Form continues on next page

IDENTIFIERS

Full Name _____ **DOB** _____

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)* } Answer question to right
- ☐ 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

*** 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 _____

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 _____

_____

_____

If the client was screened out, please list any needs the person/family has that are inadequately met by community resources:

Notes _____

_____

_____