COMPASS

A First Episode Psychosis Program

REFERRAL FORM			
Eligibility Criteria: 1. BETWEEN AGES OF 15-30 (WE ARE ABLE TO DISCUSS THOSE OUTSIDE OF THIS RANGE) 2. WITHIN 2 YEARS OF FIRST ONSET OF PSYCHOTIC SYMPTOMS 3. HAVE RECIVED DIAGNOSIS OF SCHIZOPHRENIA OR OTHER PSYCHOTIC DISORDER, EVEN IF UNSPECIFIED 4. MUST BE A RESIDENT OF DENTON COUNTY 5. PSYCHOTIC SYMPTOMS ARE NOT PRIMARILY SUBSTANCE-INDUCED OR BETTER EXPLAINED BY SUBSTANCE USE			
Date:		Client Name:	
DOB:	Age:	Gender:	
Address:			
Telephone #:	Alternative #:		

Name of Caller:		Relationship to Client:	
Organization:		Email address:	
Insurance Provider:		Member ID:	

REFERRER INFORMATION (CIRCLE ALL THAT APPLY)			
Inpatient Psychiatric Hospital	Outpatient Mental Health Clinic-Psychiatrist	Outpatient Mental Health Clinic-Therapist/Counselor	Primary Care/Pediatrician
Adult Medicine/Primary Care	School-Based Services	Emergency Room/Hospital	Justice System/Probation
Self	Family/Friend	Other:	
Name of Referring Organization			

HOW DID YOU HEAR ABOUT COMPASS?

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INFORMATION ABOUT THE REFERRED INDIVIDUAL				
Are they currently in treatment?	YES	NO	If YES, who is the provider?	
Current Diagnosis (if applicable)?:				
Are they taking medications?	YES	NO	If YES, what are they and dosages:	
Have they been hospitalized for psychiatric reasons?	YES	NO	If YES, # of times, when, and where?	

PSYCHOSIS INFORMATION: IS THE INDIVIDUAL YOU ARE REFERRING EXPERIENCING ANY OF THE FOLLOWING?		
Changes in thinking (odd ideas, grandiosity, suspiciousness, difficulty Concentrating)	YES	NO
Changes in perception (auditory/visual/tactile/smell abnormalities)	YES	NO
Changes in speech (disorganized communication, changing topics, not making sense)	YES	NO
Emotional changes (depression, mood swings, irritability, lack of emotional expression)	YES	NO
Dramatic reduction in overall functioning (decline in personal hygiene, decline in school or work abilities)	YES	NO
Family history of severe mental illness (_____)	YES	NO
Any medical conditions involving head injuries or seizures?	YES	NO
Special Education and Learning Concerns	YES	NO
Estimated date of onset of the above symptoms?		

FRIENDS AND FAMILY OR SELF REFERRAL ADDITIONAL INFORMATION
Please describe what you or your loved one has been experiencing over the past month?
How did you or your loved one function before the onset of these symptoms? (Examples: school/work, relationships, daily activities, or hygiene.)