Early Intervention in Psychosis Team Referral Form

Bucknall Hospital, Eaves Lane, Bucknall, Stoke-on-Trent ST2 8LD • Tel/Fax No: 01782 275036

REFERRAL INFORMATION	
PLEASE COMPLETE IN FULL **Referring Agent:** **Tel No:** **Name of Referrer:** **Date referral form filled in:**	**TO BE COMPLETED BY EARLY INTERVENTION SERVICES** **Date referral form received by EIS:** **Notes requested:** **Received : Yes/No**
REASON FOR REFERRAL **(Please include current presentation):**	

CLIENT'S PERSONAL DETAILS	
***Mr/Mrs/Miss/Master (please delete)** **Client Name:_** _____ **Address:** _____ _____ **Tel No:** _____ **DOB:** _____ **Age** _____	**Unit Number:** _____ **Gender:** _____ **Ethnic Origin:** _____ **Language Spoken** _____ **Interpreter required: Yes/No**
RELEVANT CONTACTS	
GP Name: _____ **GP Address:** _____ _____ **GP Tel No:** _____ **Current RMO:** _____	**Next of Kin:** _____ **Tel No:** _____ **Relationship:** _____ **Address** _____ _____
ANY OTHER PEOPLE INVOVLED	
Name: _____ **Relationship:** _____ **Address:** _____ **Tel No:** _____	**Name:** _____ **Relationship:** _____ **Address:** _____ **Tel No:** _____

North Staffordshire Combined Healthcare NHS
NHS Trust

Completed by Signature …….. Date ……..…….

Please provide client's brief personal and social history (eg, living situation, family, developmental issues)

Previous Contact with Psychiatric Services: Yes/No

If Yes, please provide details:

_____

_____

_____

_____

Current Medication:

_____

Previous Medication:

_____

Number of Hospital Admissions/Home Treatment Contacts and corresponding dates:

_____

_____

_____

Please state any physical problems:

_____

Risk History

Self Harm (current & previous) : _____

_____

Threat to others (current & previous):_____

_____

Substance Use (current & previous): _____

_____

Self Neglect (current & previous):_____

_____

Exploitation/harm from others (currernt & previous): _____

_____

Completed by Signature …….. Date ……..…….

Reported evidence of (please tick box)	
1. Paranoid ideas/ideas of reference ☐	*Comments*
2. Thought disorder ☐	*Comments*
3. Hearing/Seeing things ☐	*Comments*
4. Odd beliefs ☐	*Comments*
5. Inappropriate affect ☐	*Comments*
6 First degree of family history of Psychosis plus ☐	*Comments*

Reported symptoms (please tick box)	
1. Sleep difficulties ☐	*Comments*
2. Social isolation ☐	*Comments*
3. Depressive mood ☐	*Comments*
4. Poor concentration ☐	*Comments*
5. Agitation ☐	*Comments*
6. Physical health, any known difficulties ☐	*Comments*
7. Decrease in functioning ☐	*Comments*
8. Family concerned ☐	*Comments*
9. Excess use of alcohol ☐	*Comments*
10. Excess use of drugs ☐	*Comments*

Accepted	☐	Referred Back	☐	Signposted	☐

Completed by Signature …….. Date ……..…….