First Contact Assessment Service Referral Form

TO BE COMPLETED BY REFERRING PROVIDER

Please indicate the type(s) of assessment being requested (mark all that apply):

____**Psychosis Risk Assessment** (evaluation of possible emerging schizophrenia/other psychotic disorder).
Please note: If there are already clear and active psychotic symptoms (such as clear and prominent hallucinations and delusions), and particularly if there are any immediate safety concerns, then referral of the patient to an emergency room for potential inpatient psychiatric admission would be more appropriate.

Indicate any of the following psychosis risk factors that are present (check all that apply):

___Family history of a psychotic disorder (such as schizophrenia).
If family history present, are first-degree relatives (parents, siblings) affected?: _____
___Symptoms suggestive of possible psychosis (i.e., hallucinations, delusions, odd thinking or behavior).
___Substantial deterioration in functioning within the past year.
___Genetic condition that is known to increase the risk for schizophrenia (such as 22q11 deletion).
Specify any known genetic condition:_____

____**Psychiatric Genetics Assessment** (patient has known genetic condition with possible psychiatric manifestations).
Specify the known genetic anomaly, disorder, or condition: _____

____**Complex Neurodevelopmental Disorder Assessment** (two or more of the following problems present).
Please check all of the following problems that apply:

___Definite or suspected Attention-Deficit/Hyperactivity Disorder (ADHD)
___Definite or suspected Autism Spectrum Disorder
___Definite or suspected Tic Disorder, or other movement disorder
___Definite or suspected Developmental Coordination Disorder
___Known neurological disorder (specify type of disorder: _____)

Please note: The First Contact Assessment Service will not take over psychiatric management of referred cases, but will provide an evaluation report with recommendations to the referring provider (and to additional treating mental health professionals as requested). Please provide contact information for treating providers who should receive a copy of the report.

PLEASE PROVIDE THE FOLLOWING CONTACT INFORMATION:

Name of potential patient:
D.O.B.:
Sex:
Age:
Phone number:

Name of Parent/Guardian:
Phone number:

Name of referring Physician or Mental Health Provider:
Phone number:

Name of primary care Physician:
Phone number:

Name of psychiatrist:
Phone number:

Name of psychologist or psychotherapist:
Phone number:

SCREENING QUESTIONS FOR REFERRING PROVIDER:
(Please answer as many of these questions as possible.)

Name of person answering questions:
Date questions answered:

1. In one sentence, what is the **main psychiatric concern** regarding the patient?

2. Has there been **worsening of school, work, or social functioning** in the past year?

3. Does the patient or patient's relative report **odd experiences or behaviors**? (Describe briefly.)

4. Has the patient had **auditory or visual hallucinations**?

5. Does the patient have **strange ideas/beliefs**?

6. Were there **motor or speech delays** in early childhood (for example, slow to walk or talk?)

7. Are there any difficulties with **motor coordination or clumsiness**?

8. Was childhood **social development** delayed or abnormal?

9. Are there problems with **attention, learning, or thinking**?

10. Does the patient use **alcohol or substances**?

11. Does the patient have any **active medical problems**?

12. Have there been **previous psychiatric diagnoses**? (List any diagnoses)

13. Are there any **current medications**? (List medications)

14. Is there a **family history of psychotic disorders** such as schizophrenia, bipolar disorder, or depression with psychosis?

15. Has the patient had **genetic testing**? (If so, please specify type of testing and results)

16. Has the patient had psycho-educational, neuropsychological, or other formal **cognitive testing**? (if so, when and where was the testing done?)

17. Has the patient had a **brain MRI or other additional testing** that may be relevant? (If so, please provide results)

18. Does the patient receive **educational accommodations or services**, or are there concerns that this may be needed? (Also, please indicate if child has IEP or 504 plan in place.)

19. **To which provider(s) should the First Contact reports be sent?** (List provider name(s) here, and make sure the names/contact information for the provider(s) is listed on page 1 of the referral form.)

IF YOU HAVE ADDITIONAL SPECIFIC CONCERNS REGARDING NEURODEVELOPMENTAL ISSUES OR OTHER PROBLEMS THAT SHOULD BE EVALUATED, PLEASE PROVIDE DETAILS HERE: