**Early Intervention in Psychosis Referral Form**

**Please note: The EIT service only works with people experiencing a suspected First episode psychosis,** if the client has been diagnosed or treated previously for psychosis please refer to CAMHS for children and to CMHT for those who have reached their 18th birthday.

The team will accept referrals with evidence of a combination of symptoms which will be primarily positive however may also include negative symptoms. Please see below for a checklist of symptoms indicative of psychosis.

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| --- | --- | --- | --- |
| **Mr/Mrs/Ms/Miss** |  | **Date of Birth** |  |
| **Surname** |  | **Forename** |  |
| **Address** |  | **Preferred Name** |  |
| **Male/Female** |  |
| **Post Code** |  | **NHS Number** |  |
| **Email** |  | **Mobile Telephone** |  |
| **Home Telephone** |  | **Preferred Contact** **Number** |  |
| **Next of Kin** |  | **Marital Status** |  |
| **Ethnicity** |  |  |  |
| **Has this person consented to this referral? YES/NO** (Delete as approapiate)**If the person is under 18 years of age:*** **Is the parent/guardian aware YES/NO**
* **Are they Gillick Competent YES/NO**
 |
| **GP Name**  |  | **GP Surgery** |  |
| **Referral Source and contact details:****Referral date:** |  | **\*if GP referral please also complete Part B of this form** **GP Patient Profile included** | 🞏   |
| **Reason for Referral** |  | **Please give examples of when the individual experiences any of the following and for how long:** |
| **Voice hearing with an accompanying belief that what they are hearing is real.**  |  |
| **Hearing, seeing, feeling, tasting things that others cannot.** |  |
| **Command hallucinations** |  |
| **Paranoid ideation including a lack of insight into the nature of voice hearing.** |  |
| **Conspiracy beliefs**  |  |
| **Decline in social functioning**  |  |
| **Social withdrawal** |  |
| **Thought insertion/removal** |  |
| **Sometimes see special meanings in day to day situations for example: the way things are arranged, numbers, TV, radio.**  |

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| **New feelings of being very important or having a special purpose** |  |
| **Other experiences.** **(lack of drive, emotional apathy, poverty of speech, self-neglect).**  |  |
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| **If you wish to have a discussion regarding this referral then please call to arrange a time to discuss the** **case with a clinician.** |

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| **Concerns about Risk: (self, others, children, any safeguarding concerns)** |  |
| **Presenting situation:** |  |
| **Current treatment provided:** |  |
| **Other relevant details.**  |  |

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| --- | --- |
| **Form Completed by:** |  |
| **Date:** |  |
| Date form received:[office use only] |  |

**Please note that Early Intervention in Psychosis Service aims to assess all triaged referrals within 14 days**

**Please ensure that the patient has agreed to the referral to the Early Intervention Team as we will be unable to proceed with triaging the referral if the patient is unaware. If the patient refuses a referral to the Early Intervention Team please consider the patients capacity to make an informed decision to consent to the referral.**

**If a Mental Health Act assessment is required please contact the appropriate local Community Mental Health Team manager to discuss.**

Please contact:

Early Intervention in Psychosis (EAST Cornwall)

01208 834276

Early Intervention in Psychosis (WEST Cornwall)

01209 204003

Please email completed form to:

Cpn-tr.cornwallearlyinterventionpsychosis@nhs.net

Part B

Physical Health Records provided by GP

|  |  |
| --- | --- |
| Height |  |
| Weight |  |
| BMI |  |
| Blood pressure |  |
| Smoker Y/NHow many per day |  |
| Alcohol ConsumptionUnits per week |  |
| Previous Medical History (please include patient profile) |  |