Patient ID: _____ Clinic: _____ Date: ____/____/____

REFERRAL FORM

Client ID (Client name or unique ID)	
Date referral was received (mm/dd/yyyy):	
Date referral screening was completed (mm/dd/yyyy):	
Is this a new admission or transfer from another CSC program?	○ New admission ○ Transfer
Complete the following for clients that are new to your program.	
What was the urgency/level of need of the referral? An **emergent need** is a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self. An **urgent need** is a condition in which a person is not imminently at risk of harm to self or others, but by virtue of the person's substance use or condition, could rapidly deteriorate to an Emergent need without immediate intervention and/or diversion. A **routine need** is a condition in which the person describes signs and symptoms resulting in (a) impaired behavioral, mental or emotional functioning which has impacted the person's ability to participate in daily living or markedly decreased the person's quality of life, or (b) an impairment which can likely be diagnosed as a substance abuse disorder.	○ Emergent ○ Urgent ○ Routine
Is the client currently in treatment with another outpatient provider for the psychotic disorder?	○ Yes ○ No
Referral Source(s) (Select all that apply.):	○ Self-referred ○ Family ○ Inpatient psychiatric facility ○ Medical hospital ○ Mental health provider ○ Community health provider (e.g., PCP) ○ School system or university provider ○ Police or criminal justice ○ Day treatment program ○ Other (specify):
If applicable, what is the name of the referring provider, hospital, or agency?	
County of Residence:	
Was the intake appointment scheduled?	○ Yes ○ No
If scheduled, date of appointment (mm/dd/yyyy):	
If not scheduled, what was the reason (may select multiple):	○ Could not reach ○ Client declined ○ Outside of catchment area ○ Doesn't meet program admission criteria ○ Waitlisted, appointment to be scheduled at a later date ○ Other (specify):

If client declined, please specify reason(s):	○ Transportation issues ○ Distance or travel time to clinic ○ Program intensity/frequency of visits ○ Financial concerns ○ Other (please specify: _____)
If client does not meet program admission criteria, please specify reason(s):	○ Too young (age less than 15) ○ Too old (age over 30) ○ Duration of psychosis greater than 3 years ○ No psychosis or attenuated psychosis symptoms ○ Client meets criteria for clinical high risk for psychosis (attenuated symptoms of psychosis) ○ Psychosis symptoms secondary to drug use ○ Client is experiencing psychosis symptoms, and has a significant developmental disorder that is the primary focus of treatment ○ Specify other reason (example: client does not meet criteria for a primary psychotic disorder, but does experience some symptoms of psychosis):
If client was not scheduled for an intake appointment, where will they receive services?	○ Currently in treatment, will continue with current care ○ Currently in treatment, will receive care with a different provider ○ CSC helped client connect to a higher level of care (inpatient psychiatric, residential, PHP, inpatient substance use treatment) ○ CSC helped client connect to outpatient substance use treatment program ○ CSC helped client connect to another outpatient provider ○ Client refuses treatment ○ Client is seeking alternative provider ○ Unsure ○ Other (specify):
Follow-up questions for waitlisted clients.	
Date of re-contact:	
Was the intake appointment scheduled?	Yes
If scheduled, date of appointment:	○ ○ No
If not scheduled, what was the reason? (May select multiple.)	○ Could not reach ○ Client declined ○ Doesn't meet program admission criteria ○ Clinic not accepting new clients ○ Other (specify):