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**New Journeys Referral Form**

New Journeys is a comprehensive, treatment match program for individuals who have experienced First Episode Psychosis. This form is a request that an individual will be *screened* for New Journeys, acceptance into New Journeys will be based on further screening and assessment. Individuals who are being referred should continue to follow up with their existing providers during the assessment period.

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| Referral Date: Click or tap to enter a date. | Is the individual aware of the referral? [ ] Yes [ ]  No |
| Referred by: Click or tap here to enter text.Agency/Relationship to individual being referred: Click or tap here to enter text. | Referent Phone #:Click or tap here to enter text. |
| What kind of insurance does the youth/young adult have:[ ] Medicaid     [ ]  Private Insurance Click here to enter text.         [ ]  No Insurance |
|  |  |  |
| Name of referred individual: Click or tap here to enter text.DOB Click or tap here to enter text.Identified Gender: Click or tap here to enter text.Preferred Pronouns: Click or tap here to enter text.Resident of Pierce/Grant County[ ]   | Address:Click or tap here to enter text.  |
| Phone: Click or tap here to enter text. |
| Name/phone # of parent/primary care giver if applicable: Click or tap here to enter text. |
| Race/ethnicity: Click or tap here to enter text.Hispanic origin? [ ]  Yes [ ]  No | Highest grade level completed:Click or tap here to enter text.School: Click or tap here to enter text. |
| Does the referred individual have an existing mental health diagnosis? [ ]  Yes [ ]  NoPlease list any known diagnoses: Click or tap here to enter text. |
| Is the individual already receiving services for mental health? [ ]  Yes [ ]  NoIf yes, where? Click or tap here to enter text. |
| Reason for Referral: Click or tap here to enter text.  |
| Please review the following items and check all that apply:[ ]  The individual’s speech doesn’t make sense [ ]  The individual has behaviors, speech, or beliefs are uncharacteristic and/or bizarre[ ]  The individual reports hearing voices or sounds that others do not [ ]  The individual feels that other people are putting thoughts in their head, stealing their thoughts[ ]  The individual believes others can read their mind (or vice versa)[ ]  The individual believes that they do not exist or that their surroundings are not real [ ]  The individual has experienced a significant decline overall functioning [ ]  The individual has experienced significant changes in sleep (sleeping less or sleeping too much)[ ]  The individual has been experiencing increased fear or anxiety for no apparent reason [ ]  There is a family history of major psychotic disorder[ ]  The individual has an existing diagnosis of autism spectrum disorder[ ]  The individual has a history of Drug/marijuana/alcohol use (list substances used below):Click or tap here to enter text. |
| Is the individual experiencing any other symptoms not listed? [ ]  Yes [ ]  NoPlease explain: Click or tap here to enter text.  |
| When did you first notice these changes in the individual being referred? Click or tap here to enter text.  |
| Safety Concerns? Click or tap here to enter text.  |
| Has the individual ever been prescribed antipsychotic medication? [ ]  Yes [ ]  No What medications are currently being prescribed? Click or tap here to enter text.Who is prescribing the medications? Click or tap here to enter text. |
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\*\***If you are referring from a mental health agency or psychiatric hospital, please send a copy of the individual’s most recent Psychiatric Evaluation or Intake to expedite the referral/screening process**\*\*

PROGRAM ELIGIBILITY REQUIREMENTS

1. Age: 15-40
2. Resident of Pierce county

3) Psychotic Sxs: Present between 1week and 2 years

 4) Primary Dx: Schizophrenia, Schizoaffective, Schizophreniform, Brief Psychotic, Delusional, or Other Specified Psychotic Disorder

\*Exclusion Criteria: Psychosis is due primarily to 1) substance intoxication and/or withdrawal, 2) a medical condition, or 3) a current dx of Mood Disorder, Pervasive Developmental Disorder, and/or Autism Spectrum Disorder; Documented IQ <70.

Submit form to:

Fax: {509-919-4877}

For Pierce County residents Email: NJPierce@Clarvida.com

For Grant County residents Email: NJGrant@Clarvida.com

Questions? Pierce County: Emily Donoghue; 425-530-8945 Grant County: 509-209-8990