NAVIGATE REFERRAL FORM

Empowering healthy futures by helping individuals navigate First Episode Psychosis.

CLIENT INFORMATION

Client Name ______________________________ DOB ______________
First Name Last Name MM/DD/YYYY

Address ______________________________ Primary Phone ______________
Street City State Zip Secondary Phone ______________

Legal Status ______________________________ Email Address ______________

PARENT/LEGAL GUARDIAN INFORMATION – IF APPLICABLE

Name ______________________________ Relationship ______________
First Name Last Name Describe

Address ______________________________ Primary Phone ______________

Email Address ______________________________ Secondary Phone ______________

SYMPTOMS PRESENT *Check all that apply*			
☐	Loss of contact with reality	☐	Delusional thoughts or false beliefs
☐	Suspicion that others want to harm them	☐	Grandiosity and elevated mood
☐	Verbally disorganized	☐	Behaviorally disorganized
☐	Hallucinations *(hearing, seeing, smelling, or feeling things which others do not)*		
CURRENT DIAGNOSIS *Check all that apply*			
☐	Schizophrenia	☐	Bipolar Disorder
☐	Schizoaffective Disorder	☐	Intellectual Disabilities *(IQ less than 70)*
☐	Schizophreniform Disorder	☐	Autism Spectrum Disorder
☐	Substance Induced Psychosis	☐	Other
CURRENT MEDICATION(S)			
Type:		☐	Been prescribed for over 12 months?
Type:		☐	Been prescribed for over 12 months?
Type:		☐	Been prescribed for over 12 months?
ADDITIONAL INFORMATION *List any pertinent information*			

REFERRAL SOURCE

Referral Name ______________________________
First Name Last Name

Organization ______________________________ Primary Phone ______________

Email Address ______________________________ Secondary Phone ______________

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