Saskatchewan Health Authority

Mental Health & Addiction Services
Saskatoon Area

Name: _____

HSN: _____

DOB: _____/_____/_____
(yyyy/mm/dd)

Early Psychosis Intervention Program
Room H170, 103 Hospital Drive
Royal University Hospital, Hantelman Bldg
New Referrals Questions - Intake Phone: 655-7777 Fax: 655- 0186

New Referral Information

Inclusion Criteria:

Less than 35 years old
Positive/negative/disorganized symptoms of psychosis
Prodromal symptoms of psychosis
Evidence of genetic predisposition plus declining global assessment of function
Able to attend multi-disciplinary services *located in Saskatoon*

Exclusion Criteria:

More than 3 months of therapeutic treatment with anti-psychotic medication
Significant impairment due to cognitive or developmental deficit
Other psychosis – e.g., substance-induced, mood or personality disorder

Demographic Information

Address: _____ Postal Code: _____

Telephone: Residence _____Other _____

Occupation: _____Education: _____

Male _____ Female _____ Transgender _____

Living Arrangements: _____In Hospital: RUH: _____SCH: _____ SPH: _____

Referring Consultant: _____ Family Physician: _____

Referral Source: _____

Current Psychotic Symptoms (please check - include time frames and frequencies):

- ☐ Delusions _____
- ☐ Hallucinations _____
- ☐ Disorganized thought/speech _____
- ☐ Negative symptoms _____

Prodromal Symptoms: (please check)

- ☐ Social withdrawal
- ☐ Deterioration in normal functioning
- ☐ Significant anxiety/depression
- ☐ Suspicion
- ☐ Odd behaviour/appearance

Significant Medical Issues – Past and Present (e.g., psychiatric care, seizures, head injury, etc.):

Medication/Treatment History and Response (e.g., voluntary/involuntary):

Other Developmental/Social/Childhood/Behavioural Issues:

Family History of Mental Illness:

Substance Use History:

Legal Status/Criminal Involvement:

Please provide collateral information:

Name: _____ Relationship to Client: _____

Contact Numbers: _____

Secondary Contacts: _____

Other Agencies or Service Providers (please check):

- ☐ MSS/CLD
- ☐ ABI
- ☐ Autism Services
- ☐ Other: _____

Is the patient in agreement with this service request? (please check)

- ☐ Yes
- ☐ No

Please Fax Completed Form and Collateral Information to (306)655-0186