BETTER MORNING
FEP Referral Form & Screening Tool
First Episode Treatment Team

Inclusion Criteria

- Individuals between ages 16-25 at assessment
- First episode of psychosis (FEP) was within the last year
- No previous diagnosis of Intellectual Developmental Disability
- Substance Use Disorder is not primary diagnosis
- Psychosis was not solely substance-induced
- Must live in the District of Columbia

Patient Information

Name: ______________________________ Date of Birth: ____________________

Gender: _____________________________ Pronouns: _______________________

Address: ____

Phone: (home/cell) _____________________________

Parent/Legal Guardian: ___________________________

Phone: (home/cell) ________________________ (work) _________________________

Emergency Contact: _________________________Relationship: _________________

Phone: (home/cell) ________________________ (work) _________________________

Primary Insurance Company: ___________________ **ID Number:** ________________

Policy Holder Information (if other than self)

Name: ______________________________ Relationship: ____________________

Address: ____

Primary Care Physician:

Provider Name: ____

Address: ____

Phone: _______________________ Fax: _______________________

Referral Source Information

Clinic/Facility/ Name: ________________________________ Date: ___________________

Provider Name(s): _________________________Phone:______________________

Address: ____

Fax: _________________________ E-mail: _______________________________

Reason for Referral:

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Mental Health History

Date of onset of psychotic symptoms: ____

Date of first contact with current provider: _______________________________________

Current Psychotic Symptoms: (Check all that apply)

Delusions

Hallucinations

Disorganized Thinking/Speech

Disorganized Behavior

Current Substance Use: ____

Current Suicidality: ____

Current Aggression/Violence: ____

Current Prescribed Medications: ____

Current Legal Involvement: ____

Is the patient currently under an Outpatient Commitment Order? ______________________

Past Hospitalizations:

Reason for Admission: ____

Facility Name: ____

Address: ____

Phone: _________________________ Fax: _________________________

Date of Admission: ______________________ Date of Discharge: ____________________

Reason for Admission: ____

Facility Name: ____

Address: ____

Phone: _________________________ Fax: _________________________

Date of Admission: ______________________ Date of Discharge: ____________________

Previous Outpatient Providers:

Provider Name: ____

Address: ____

Phone: _________________________ Fax: _________________________

Date of Admission: ______________________ Date of Discharge: ____________________

Reason for Treatment: ____

Provider Name: ____

Address: ____

Phone: _________________________ Fax: _________________________

Date of Admission: ______________________ Date of Discharge: ____________________

Reason for Treatment: ____

FOR OFFICE USE ONLY:

Date Received:

Date Screened:

Completed By:

Assigned to:

Date: