510 4th St. South, Fargo ND 58103
Fax: 701-280-5783

First Episode Psychosis - Referral Form

Referral Source

Name ___________________________

Agency___________________________

Address___________________________

____

Phone ___________________________

Client Name:____Date:____________________

Address:________________________________DOB:______________Age:__________

________________________________Primary Phone:______________________

________________________________Alternate Phone:______________________

Does client have: ☐ spouse ☐ parent ☐ guardian ☐ other:____________________

Marital Status: ☐ single ☐ married ☐ separated ☐ divorced

Was the psychotic episode related to: ☐ substance use ☐ medications ☐ medical issues ☐ other psychiatric disorder: ____________________________ ☐ unknown

Was client hospitalized as a result of the psychosis: ☐ yes, when ______________ ☐ no

Is client currently in school: ☐ yes, current grade: ________; ☐ no ☐ enrolled but not attending

Is client currently employed: ☐ yes ☐ no

Past/current psychiatric providers:

Is the client seeing other professionals for psychiatric issues? (family practitioner, inpatient, psychiatrist, therapist, etc.)
If so, please specify:

Name:	Location:	Reason:	Dates:
1.			
2.			
3.			

*Continue on the back of form if necessary

Medications:

Is the client on current Medications? (include ALL medications, Over the counter medications, herbal remedies)

1.______________________________ 2. ______________________________

3.______________________________ 4.______________________________

Client Signature______________________________ **Guardian Signature**______________________________

Please send this form to Prairie St. John's Clinic, 510 4th Ave. So., Fargo, ND 58103 or Fax to: 701-280-5783