SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE
iCare

DEMOGRAPHIC LABEL

Early Psychosis Intervention (EPI) Referral Form

Fax to Transitional Care at (705)256-3469

Patient Name:					
Address:					
Telephone (home):		Telephone (work):			
Date of Birth:		Ontario Health Insurance Number:			
Referred by:		Agency:			
Address:		Telephone:		Fax:	
Family Physician:		Family Physician Notified:	☐ Yes ☐ No		
Date of onset of symptoms:					
Description of symptoms:					
Other medical history:					
Current medications (dose, duration):					
Signature of referring agent:					

CRITERIA: adults from age 16 – 35 years experiencing symptoms of psychosis or possible early symptoms of a psychotic illness who have not been treated for more than a period of twelve months.

NOTE: multidisciplinary care is provided for those individuals accepted to the program for a period of 2 – 3 years based on the client's medical and psychosocial needs. In the stable phase of the illness, clients will be referred back to the community for ongoing care.