|  |  |  |
| --- | --- | --- |
| **Referral Date** |  | |
| **Client’s Name** | **DOB:** | |
| **NHS Number**  *If known* |  | |
| **Address** | ***Verified as correct: Y / N*** | |
| **Telephone** | ***Verified as correct: Y / N*** | |
| **Interpreter Required?** | **Y / N**  **Language:** | |
| **Physical/Learning Disabilities?** | **Y / N**  **Details:** | |
| **Is the client aware that a referral has been made and consent has been given?** | **Y / N**  **Details:** | |
|  |  | |
| **Referrer Name** |  | |
| **Agency** |  | |
| **Job Title** |  | |
| **Referrer Address** |  | |
| **Telephone** |  | |
|  |  | |
| **GP Details** *Is GP Newcastle CCG?* |  | |
| **GP Telephone** |  | |
|  |  | |
| **Reason for Referral** | | **Please Answer – Yes / No** |
| First presentation of psychotic symptoms? | |  |
| Age 14-65? | |  |
| Previous involvement with EIP services?  *If yes, how long and when?* | |  |
| Has an organic cause been eliminated?  *Example: head injury, epilepsy, UTI* | |  |
| Previous history of prescribed antipsychotics?  *If yes, what and when?* | |  |
|  | |  |
| **Psychotic Symptoms**  Evidence of voice hearing, unusual ideas, paranoia, visions?  *If yes, please give details, e.g. What, where, content, frequency, duration.* | |  |
| Have psychotic symptoms lasted longer than 7 days? Do they happen every day or less frequently? | |  |
| Have psychotic symptoms remitted within 7 days without treatment? *Consider if could be BLIP* | |  |
| **Evidence of distress?**  If yes, please give details: | |  |
| **Deterioration in functioning?**  If yes, please give details: | |  |
| **Family concerns?**  If yes, please give details: | |  |
| **Family history of psychosis / “Schizophrenia”?**  If yes, please give details: | |  |
| **Any involvement with services in the past or currently?**  If yes, please give details: | |  |
| **Current or past drug or alcohol use:** | |  |
| **Is the person currently intoxicated?** | |  |
| **Have symptoms subsided following withdrawal of substances?** | |  |
| **When did you first suspect Psychosis or At Risk Mental State?** | |  |

|  |
| --- |
| **Risks** |
| **Forensic history:** |
| **Self-harm/suicide attempts:** |
| **Children under 18 in the household:** |
| **Any known concerns?**  *Example: previous assaults on staff/others* |
| **Any issues regarding neglect?** |
| **Do you have potential safety concerns for professionals visiting this person at home?** |

Please send referral via email to [EIPAdminNewcastle@cntw.nhs.uk](mailto:EIPAdminNewcastle@cntw.nhs.uk)

You can contact us on 0191 287 6210 if you require any assistance filling in this form.

Once referral is received, we may contact yourself or the client for further information, please ensure you have included accurate contact details so we can be in touch if required.

We aim to offer an assessment, if appropriate, within 14 days of receipt of referral however if you require urgent support, please contact the relevant Crisis Team on the details below:

**Newcastle & Gateshead Crisis Team:**

Telephone: 0191 814 8899 or freephone 0800 652 2863

Text Service: 07919 228 548 (for those who are deaf or have communication difficulties)

**Northumberland & North Tyneside Crisis Team:**

Telephone: 0800 652 2861

Text Service: 07887 625 277 (for those who are deaf or have communication difficulties)