

## ABUHB Early Intervention in Psychosis Service Referral Form

Form to be completed in full and returned via email to  
[ABB.EISReferrals@wales.nhs.uk](mailto:ABB.EISReferrals@wales.nhs.uk)

The service is for anyone aged 14-35 who has experienced a first episode of psychosis in the last 3 years. The primary problem should be psychosis, rather than a mood or personality disorder; however we welcome uncertainty about diagnosis and encourage referrals for a second opinion.

**Please refer as soon as you suspect psychosis; the sooner the better.**

### Client Details

Name:			
DOB:		EPEX:	
Address:			
Telephone No:		Mobile No:	
Client aware of referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

### Referrer Details

Name:		Date:	
Contact No:		Team:	

### Patient Information

Does the person have a known diagnosis:	<input type="checkbox"/> Yes <input type="checkbox"/> No State:	
Is the patient receiving medication:	<input type="checkbox"/> Yes <input type="checkbox"/> No State:	
Has the person experienced an episode of psychosis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the onset of symptoms within the critical three year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the person have any of the following symptoms:	Auditory Hallucinations	<input type="checkbox"/>
	Delusions	<input type="checkbox"/>
	Thought disorder	<input type="checkbox"/>
	Cognitive Dysfunction	<input type="checkbox"/>
	Changes in functioning	<input type="checkbox"/>
Distress	<input type="checkbox"/>	
Does the person have a family history of mental illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No State:	
Has the patient been diagnosed with Bipolar Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the person been diagnosed with a primary substance-induced psychosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**CTP Details**

Care Coordinator:	
Has the CTP Assessment been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No – State Reason below:
Date of last CTP:	
Date of next CTP:	
Have you attached the latest Care and Treatment Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No – State Reason below:

**Risk Assessment**

Has a WARRN been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No – State Reason below:
WARRN Attached:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Red Flag:	<input type="checkbox"/> Yes <input type="checkbox"/> No State Reason below:

**Reason for referral**

(Please provide a brief history of presentation. It would be helpful if you could indicate symptoms suggestive of psychosis)

<input type="checkbox"/> Second Opinion <input type="checkbox"/> Assessment for EIS Service <input type="checkbox"/> Joint Working
<i>Please continue on further paper if necessary</i>

Office Use Only: Office Use Only:

Date ref received:	
Date ref discussed:	
Above details complete & correct:	
CaTP attached:	
WARRN attached:	