## iHOPE Program – Screening/Consultation Form

## CLIENT INFORMATION:

Name: Phone number:

Address: County of residence:

D.O.B.: Living situation:

## REFERRAL SOURCE INFORMATION:

Name: Organization/relationship to client:

Phone: Email:

HOW DID YOU LEARN ABOUT IHOPE? Circle all that apply

Outreach/Brochure/Flyer/online/family member/professional/other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLINICAL INFORMATION:

1. **Is the client currently in treatment? YES/NO**

**Where? For What?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Does the client have a current diagnosis? YES/NO**

**What is the diagnosis?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Is the client taking any medications? YES/NO**

**What are they and for what reason? \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Has the client been hospitalized for psychiatric reasons? YES/NO**

**When and where? \_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Is the client experiencing any of the following?**

**\_\_\_Changes in thinking (odd ideas, grandiosity, suspiciousness, difficulty concentrating)**

**\_\_\_Changes in perception (auditory/visual/ tactile/ olfactory abnormalities)**

**\_\_\_Changes in speech (disorganized communication, tangential speech)**

**\_\_\_Emotional changes (depression, mood swings, irritability, flat affect)**

**\_\_\_Dramatic reduction of overall functioning**

**\_\_\_Family history of mental illness? Psychosis? First degree relative?**

**\_\_\_Any medical conditions or head injuries?**

**\_\_\_Special education/IQ issues, below 70?**

**OFFICE USE ONLY**

## REFERRAL DECISION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Decision date:**

**Person making decision:**

**Screened in: YES/NO**

* First episode psychosis, onset of DSM 5 psychotic disorder within 12 months

Onset date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* First episode psychosis, onset of DSM 5 psychotic disorder greater than 12 months by exception

Onset date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Symptoms consistent with Psychosis risk syndrome
* Further assessment needed to assess appropriateness
* Family history with decline in functioning
* Other reason (specify) \_\_\_\_\_\_\_\_\_

**Screened out: YES/NO**

* No symptoms of psychosis
* IQ under 70
* Age
* Onset of DSM 5 psychotic disorder greater than 12 months(specify timeframe)
* Client/Family declined
* Left area before engaging
* Differential diagnoses not consistent with primary psychotic disorder
* Long-term incarceration
* Unable to assess/engage referred person (place details in notes)
* Other reason (specify)

If the client was screened out, to what alternative services was the client directed?

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Notes:

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