HEGIRA HEALTH, INC.
Wellness First

# NAVIGATE REFERRAL FORM

*Empowering healthy futures by helping individuals navigate First Episode Psychosis.*

## CLIENT INFORMATION

Client Name _____ _____ DOB _____
First Name Last Name MM/DD/YYYY

Address _____ Primary Phone _____
Street City State Zip Secondary Phone _____

Legal Status _____ Email Address _____

## PARENT/LEGAL GUARDIAN INFORMATION – IF APPLICABLE

Name _____ _____ Relationship _____
First Name Last Name Describe

Address _____ Primary Phone _____

Email Address _____ Secondary Phone _____

| **SYMPTOMS PRESENT** *Check all that apply* | | | |
|---|---|---|---|
| ☐ | Loss of contact with reality | ☐ | Delusional thoughts or false beliefs |
| ☐ | Suspicion that others want to harm them | ☐ | Grandiosity and elevated mood |
| ☐ | Verbally disorganized | ☐ | Behaviorally disorganized |
| ☐ | Hallucinations *(hearing, seeing, smelling, or feeling things which others do not)* | | |
| **CURRENT DIAGNOSIS** *Check all that apply* | | | |
| ☐ | Schizophrenia | ☐ | Bipolar Disorder |
| ☐ | Schizoaffective Disorder | ☐ | Intellectual Disabilities *(IQ less than 70)* |
| ☐ | Schizophreniform Disorder | ☐ | Autism Spectrum Disorder |
| ☐ | Substance Induced Psychosis | ☐ | Other |
| **CURRENT MEDICATION(S)** | | | |
| Type: | | ☐ | Been prescribed for over 12 months? |
| Type: | | ☐ | Been prescribed for over 12 months? |
| Type: | | ☐ | Been prescribed for over 12 months? |
| **ADDITIONAL INFORMATION** *List any pertinent information* | | | |
| | | | |
| | | | |

## REFERRAL SOURCE

Referral Name _____ _____
First Name Last Name

Organization _____ Primary Phone _____

Email Address _____ Secondary Phone _____

Questions: Shannon Gabler | (734) 968-1689 | navigate@hegirahealth.org