Capital Health

Nova Scotia Early Psychosis Program

Nova Scotia Early Psychosis Program Referral Form

Patient Name: _____

Address: _____

Phone:(H) _____

(C) _____

DOB: _____

HCN: _____

PLEASE FAX THIS COMPLETED FORM TO NSEPP @ (902) 473-3456

Family Physician Name: _____ Phone#: _____ Fax #: _____

Presenting Concerns: Please include level of distress, symptoms, addiction issues, etc.:

_____

_____

_____

_____

_____

Present Medications:

_____

_____

_____

_____

Current Mental Health Providers/Community Supports (including EAP, other counseling services):

_____

Past Mental Health Treatment: (Please attach reports if available) ☐ Inpatient ☐ Outpatient

_____

_____

_____

_____

_____

Services requested: (describe)

☐ Consultation only _____

☐ Ongoing care/treatment _____

Patient is aware of referral ☐ Yes ☐ No

Referred by: _____ Date: _____

Agency / Family Practice: _____ Phone: _____ Fax: _____