New Journeys Referral Form for Thurston/Mason County

New Journeys is a comprehensive, treatment match program for individuals who have experienced First Episode Psychosis. This form is a request that an individual will be *screened* for New Journeys, acceptance into New Journeys will be based on further screening and assessment. Individuals who are being referred should continue to follow up with their existing providers during the assessment period, as acceptance into New Journeys is not a guarantee.

Referral Date:	Is the youth aware of the referral? ☐ Yes ☐ No
Referred by: Agency/Relationship to client:	Referent Phone #:
What kind of insurance does the youth/young adult have: ☐ Medicaid ☐ Private Insurance __________________ ☐No Insurance	

Name of referred individual: DOB/Age: Gender: M / F / Other: ___________________ Resident of Thurston or Mason County ☐ Yes ☐ No	Address: Phone:
Name/phone # of parent/primary care giver if applicable:	
Race (circle 1): White African-Am Asian-Am Native-Am Hispanic origin? ☐ Yes ☐ No Bi-Racial/other race (specify): _________________________________	School: Highest grade level completed:
Does the individual being referred have an existing mental health diagnosis? ☐ Yes ☐ No Please list any known diagnoses:	
Is the individual already receiving services for mental health? ☐ Yes ☐ No If yes, where?	
Reason for Referral:	

Please review the following items and check all that apply:

☐ The individual has speech that doesn't make sense or has difficulty creating sentences

☐ The individual is exhibiting behaviors, speech, or beliefs are uncharacteristic and/or bizarre

☐ The individual complains of hearing voices or sounds that others do not hear

☐ The individual feels that other people are putting thoughts in their head, stealing their thoughts, believes others can read their mind (or vice versa), and/or hear their own thoughts out loud.

☐ The individual believes that they do not exist or that their surroundings are not real

☐ The individual has experienced a significant decline in academic/vocational functioning, social functioning, and/or personal hygiene.

☐ The individual has experienced significant changes in sleep (sleeping less or sleeping too much)

☐ The individual has a heightened sensitivities to lights and sounds

☐ The individual has been experiencing increased fear or anxiety for no apparent reason

☐ There is a family history of major psychotic disorder.

☐ The individual has an existing diagnosis of Autism Spectrum Disorder

☐ The individual has a history of Drug/marijuana/alcohol use (list substances used below):

Is the individual experiencing any other symptoms not listed?☐ Yes ☐ No Please explain:
When did you first notice these changes in the individual being referred?
Safety Concerns?
Has the individual ever been prescribed antipsychotic medication? ☐ Yes ☐ No Is yes, how long has the individual taken the medication?

Please fax completed form to Becky Daughtry, New Journeys Clinical Supervisor at 360-292-4249

For more information or to consult about a potential referral contact:

Becky Daughtry, New Journeys Clinical Supervisor
360-704-7170
BHRNewJourneys@bhr.org