General Physician Referral Form
Fraser Early Psychosis Intervention Program

earlypsychosis.ca

Fax to EPI Intake:

☐ **Fraser South**	☐ **Fraser North**	☐ **Fraser East**
Fax: 604-538-4277	**Fax: 604-520-4871**	**Fax: 604-851-4826**
White Rock	Burnaby	Chilliwack
Surrey	Tri-Cities	Abbotsford
Delta	Maple Ridge	Mission
Langley	New Westminster	Hope and Agassiz
Ph: 604-538-4278	**Ph**: 604-777-8386	**Ph**: 1-866-870-7847

Referral Date: _____

Family Doctor: _____ Billing No._____

Tel. No._____Address:_____

Client Information:

☐ **No prior treatment for psychosis.** ☐ **Client is 13-30 years old**

Client's Legal Name:_____Date of Birth:_____
(dd/mm/yy)

☐**M** ☐**F** PHN: _____ Client Telephone No._____

Client Address: _____

Next of Kin: _____ ☐ Client aware of referral

Current Medication_____

Referral information: Relevant history/ presenting problems/ known risks

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Ministry of Children and Family Development