On My Way Referral

A program of
Child and Family Focus, Inc.

On My Way is a comprehensive program that supports young people (15-30) that have experienced their first episode of psychosis in the past 12 months.

Young Person's Demographic Information:

Name: _____

Referral Date: _____

Address: _____

Phone Number: _____ Alternate Phone: _____

Young Person's Email Address: _____

Date of Birth: _____ Age Today: _____

Young Person's Identified Gender: _____ Social Security #: _____

Medical Assistance #: _____ Base Service Unit #: _____

Guardian(s) Name (if applicable): _____

Current School Attending (if applicable): _____

Current School District Attending (if applicable): _____

Additional Contact Sources:

Please provide names and contact information of people who have a significant role in the young person's life (i.e. Family members, friends, neighbors, teachers, etc.):

Name/Relationship	Phone Number

Diagnostic Information:

DSM Diagnoses – To meet the inclusion criteria for On My Way, the young person must have received a primary diagnosis of schizophrenia or other psychotic disorders such as schizoaffective disorder, or bipolar disorder as defined by the DSM-5 in the past 12 months and a GAF rating of 40 or below.

Primary Mental Health Diagnosis Code and Description:

_____

_____

Additional Mental Health Diagnoses:

_____

_____

Primary Medical Diagnosis (if applicable):

_____

_____

Global Assessment of Functioning (GAF) Scale Rating: _____

System Involvement:

☐ Mental Health Outpatient Involvement
If yes, Agency Name(s) & Contact Info:

_____

_____

☐ Probation Involvement
If yes, PO's Contact Info: _____

☐ Children & Youth Involvement
If yes, CYS Contact Info: _____

☐ Office of Intellectual Disabilities Involvement
If yes, OID Contact Info: _____

☐ Drug & Alcohol Treatment
If yes, D&A Contact Info: _____

Collateral Information/Documentation:

Please check any collateral documents being provided for additional information:

☐ Medical History	☐ Psychosocial History	☐ Summary of Treatment
☐ Medications	☐ Psychological Evaluation	☐ Discharge Summary
☐ Educational Records	☐ Psychiatric Evaluation	☐ Other _____

Referral Source's Information:

☐ Young Person/ Self-Referral

☐ Natural Support
Referring Person's Name: _____
Referring Person's Phone #: _____
Does the young person want to participate in On My Way? _____

☐ Formal Support
Name of Referring Person's Affiliation: _____
Referring Person's Name: _____
Referring Person's Phone #: _____
Does the young person want to participate in On My Way? _____
*Release of Information signed by young person and attached? ☐Yes ☐No

The following information MUST be answered by the Referral Source:

Is the young person aware of and in agreement with the referral?
☐ Yes ☐ No

Comments:
_____
_____
_____

Reason for referral:
_____
_____
_____
_____
_____

Indicate the degree to which the young person's family/caregiver is involved with treatment:
☐ Low ☐ Medium ☐ High

Comments:
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please describe the psychotic symptoms that the young person has reported and/or demonstrated within the past 12 months (include the date of onset and course of qualifying symptoms, any self-harm, suicide attempts, or violent behavior):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I understand that submitting this On My Way referral does not guarantee enrollment into the On My Way program.

_____
Young Person's Signature (if applicable) Date

_____
Referring Person's Signature (if applicable) Date

Please submit the complete referral and related materials to:

Child & Family Focus
Attn: Daniel Fisher
450 Parkway Dr., Suite 210
Broomall, PA 19008
Fax: 610-325-3137
dfisher@childandfamilyfocus.org