



EASA Referral

Client's Name _____ Client's DOB _____

Client's Phone number _____

Client's address _____

Referring agency and person _____

Referring agency phone number _____

Referring agency's relationship to client _____

Reason for referral

Please mark all that apply

<p>Reports Hallucinations...</p> <p><input type="checkbox"/> Visual (seeing things other people don't see.)</p> <p><input type="checkbox"/> Auditory (Hearing things other people don't hear.)</p> <p><input type="checkbox"/> Tactile (feeling things that are not there i.e. bugs on skin: feeling like a hand is on the person)</p> <p><input type="checkbox"/> Gustatory (Tasting things that are not there.)</p> <p><input type="checkbox"/> Olfactory (smelling scents that others do not.)</p> <p><input type="checkbox"/> Reports Delusions, fixed false beliefs that cannot be corrected by logic and are inconsistent with the person's culture and education.</p> <p>Reports Perceptual changes...</p> <p><input type="checkbox"/> Fear others are trying to hurt them</p> <p><input type="checkbox"/> Heightened sensitivity to sights, sounds, smells or touch</p> <p><input type="checkbox"/> Statements like, "I think I'm going crazy" or "My brain is playing tricks on me"</p> <p><input type="checkbox"/> Visual changes (wavy lines, distorted faces, colors more intense)</p> <p><input type="checkbox"/> Feeling like someone else is putting thoughts in the brain or taking them out</p>	<p>Performance change...</p> <p>New trouble with</p> <p><input type="checkbox"/> Reading or understanding complex sentences</p> <p><input type="checkbox"/> Speaking or understanding what others are saying</p> <p><input type="checkbox"/> Coordination in sports (passing ball, etc.)</p> <p><input type="checkbox"/> Attendance or grades</p> <p>Behavior change...</p> <p><input type="checkbox"/> Extreme fear for no apparent reason</p> <p><input type="checkbox"/> Uncharacteristic, bizarre actions, statements or beliefs</p> <p><input type="checkbox"/> Incoherent or bizarre writing</p> <p><input type="checkbox"/> Extreme social withdrawal</p> <p><input type="checkbox"/> Decline in appearance and hygiene</p> <p><input type="checkbox"/> Sleep (sleep reversal, sleeping all the time, not sleeping)</p> <p><input type="checkbox"/> Dramatic changes in eating.</p> <p>Other _____</p> <p>_____</p> <p>_____</p>
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How long have these symptoms been present? _____

Please provide any relevant information about what may be going on in this person's life at this current time (i.e. socio economic change: illness: family functioning: transitions etc.)

