The Phoenix Program
Early Intervention Service

The Phoenix Program is an Early Intervention Service for Psychosis (EIP) that is a clinical outpatient program jointly managed by Joseph Brant Hospital, Halton Healthcare, ADAPT and the Schizophrenia Society of Ontario. The program is funded by the Ministry of Health and Long Term Care. We help clients who are experiencing early stages of psychosis and their families to identify their concerns and goals and to develop plans that work on recovering from psychosis. The staff available to support our clients’ recovery plans are: Family Educators, Nurses, Occupational Therapists, Psychiatrists, Substance Use Clinicians and Peer Mentors.

The eligibility criteria for the Halton Early Intervention in Psychosis program are as follows:*
1. 14 to 35 years of age and
2. are experiencing symptoms of a psychotic disorder and
3. have received either no treatment for psychosis or 6 months or less of treatment for psychosis and
4. live in the Region of Halton

Because it takes time to diagnose the underlying cause of psychosis, Phoenix will provide two types of service:
1. **Initial assessment and treatment** – which will be provided to anyone between the ages of 14 and 35 experiencing symptoms of a psychotic disorder. Through that assessment and treatment, Phoenix will determine which clients will benefit from treatment and rehabilitation in the program, and which clients should be referred to other more appropriate services. Individuals who do not have a psychotic disorder should not be admitted to the program.
2. **Intensive treatment and rehabilitation services** – which will be provided to those individuals who meet the eligibility criteria listed above (i.e. who have been diagnosed with a type of psychosis that can be treated effectively through Phoenix)

Send completed referral forms plus **relevant clinical information, including any assessments, consultations, psychiatric admissions, hospital or crisis team notes, neuropsychological testing, and rehabilitation reports** to intake at:

(Please direct fax via one-Link to Oakville Trafalgar Memorial Hospital for Oakville Residents and NHMHC for Milton, Georgetown & Acton Residents and directly to JBH for Burlington Residents.)

**OTMH**
3001 Hospital Gate
Oakville, ON, L6M 0L8
Tel (905) 845-2571 x4800
Fax (905) 338-2878

**Joseph Brant Hospital**
1230 North Shore Boulevard
Burlington, ON, L7S 1W7
Tel (905) 631-1939
Fax (905) 631-0513

**North Halton Mental Health Clinic**
217 Main St E
Milton, ON, L9T 1N9
Tel (905) 693-4240
Fax (905) 338-2878

* Early Psychosis Intervention Program Standards March 2011, Ministry of Health and Long Term Care
Phoenix Program – Early Intervention in Psychosis
REFERRAL FORM
Fax completed form to Intake at:
(Please direct fax via one-Link to OTMH for Oakville Residents and NHMHC for Milton, Georgetown & Acton Residents and directly to JBH for Burlington Residents.)

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Date: _________________________

## Client Contact Information
The person’s name: __________________________ Date of Birth
First                  Middle                  Last
(dd/mm/yyyy)

Address: __________________________ City: __________________________ Postal Code: __________

Home Phone: (____) ______________________ OK to leave a message? ☐ Yes ☐ No ☐ Unsure

HIN: __________________________ Version Code: ____________ Expiry Date:
(____) (dd/mm/yyyy)

## Referral Source Information
Referral Source: ☐ Self ☐ Family Member ☐ GP ☐ Psychiatrist ☐ Other:
☐ School ☐ ED Crisis Team ☐ Inpatient Unit ☐ COAST

Name: __________________________________ Organization: __________________________

Address: __________________________ City: __________________________ Postal Code: __________

Phone: (____) ______________________ Fax: (____) ______________________

## Family Physician Information
Does the person have a family physician? ☐ Yes ☐ No ☐ Same as Referral Source

Physician Name: __________________________ Physician’s Billing Number: __________________________

Physician Phone: (____) ______________________ Physician Fax: (____) ______________________

1) Is the person experiencing any of the following symptoms of psychosis? (Check all that apply)
☐Hallucinations ☐Delusions ☐Confused thinking ☐Mood changes ☐Cognitive changes
☐Behavior changes ☐Changes in eating or sleeping patterns ☐Paranoia
Please describe the psychosis.

________________________________________________________________________________________________________

2) How long has the person received antipsychotic treatment for psychosis?
   ☐ none   ☐ 0-6 months   ☐ 6 months +   ☐ Unknown/Client declined to answer

3) Has the client had previous hospitalizations or treatment?
   ☐ Yes   ☐ No   ☐ Unknown/Client declined to answer
   If Yes, Please specify: ________________________________

4) Where does the person live?
   ☐ Burlington   ☐ Oakville   ☐ Milton   ☐ Georgetown   ☐ Acton   ☐ Other: __________________________

5) Reason for request of service (Check all that apply):
   ☐ Assessment   ☐ Diagnosis   ☐ Treatment & Recovery Support   ☐ Extended Consultation   ☐ Other ______________________

6) Does the person experience suicidal ideation?
   ☐ Yes   ☐ No   ☐ Unknown/Client declined to answer

7) Does the person experience homicidal ideation?
   ☐ Yes   ☐ No   ☐ Unknown/Client declined to answer

8) Does the person experience aggression/violent tendencies?
   ☐ Yes   ☐ No   ☐ Unknown/Client declined to answer

9) Is there any court or legal involvement? (Charges, convictions, probation)
   ☐ Yes   ☐ No   ☐ Unknown/Client declined to answer

10) Is there any child welfare involvement/concerns?
    ☐ Yes   ☐ No   ☐ Unknown/Client declined to answer

11) Do you have concerns about the person’s use of any substances?
    ☐ Yes   ☐ No   ☐ Unknown
    If Yes, Please specify: ______________________________________

12) Does the person have a developmental disability (e.g. Down Syndrome, Autism) or intellectual deficits?
    ☐ Yes   ☐ No   ☐ Unknown/Client declined to answer
    If Yes, Please specify: ______________________________________

13) Does the person have an organic brain disorder or acquired brain injury?
    ☐ Yes   ☐ No   ☐ Unknown/Client declined to answer

14) Does the person have a primary diagnosis of a personality disorder? (e.g. Borderline Personality Disorder, Antisocial Personality Disorder, Dependent Personality Disorder, etc.)
    ☐ Yes   ☐ No   ☐ Unknown/Client declined to answer
    If Yes, Please specify: ______________________________________

April 1, 2018
15) Please list current medications, dose, and start date (year). Samples given? ☐ Yes ☐ No

__________________________________________________________________________________
__________________________________________________________________________________
___________________________________  _________________________________________________

16) Any other relevant information

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