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| **The Discovery Team Referral Form** |
| **Person Seeking Services** |

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| Date: Click here to enter a date. | Age: age. DOB: date. |
| Name: Click here to enter text. | Gender: [ ]  Male [ ]  Female |
| Address: Click here to enter text. | Preferred Pronouns: Click here to enter text. |
| City: City State: State Zip Code: Zip Code | Primary Language: Click here to enter text. |
| Phone: Click here to enter text. | Race: Click here to enter text. |
| Email: Click here to enter text. | Ethnicity (Optional): Click here to enter text. |

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| **Referral Source** |

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| Name: Click here to enter text. | Phone: Click here to enter text. |
| Address: Click here to enter text. | Email: Click here to enter text. |
| City: City State: State Zip Code: Zip Code | Relationship: Click here to enter text. |

Is the Individual aware of this referral? [ ]  Yes [ ]  No

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| **About The Discovery Team** |

The Discovery Team is an Early Psychosis (EP) Coordinated Specialty Care Team serving individuals who are 18 years of age or older who have experienced the onset of psychotic symptoms within the past two years. The Discovery Team provides trauma-informed care in a friendly, safe, and supportive environment. The Discovery Team includes a Team Leader, Prescribers, Mental Health Clinicians, Education and Employment Specialists, and Peer Specialists.

**Overview of Roles:**

* **Team Leader:** The Team Leader serves as the initial point of contact for all referrals and manages the daily functions of The Discovery Team.
* **Prescribers:** Prescribers evaluate the role of medication in treatment and work with the individual and family and/or natural supports to prescribe and manage medications.
* **Individual Clinicians:** Individual Clinicians provide individual therapy and engage the individual in NAVIGATE Individual Resiliency Training (IRT).
* **Family Clinician:** The Family Clinician serves as the point of contact for the individual’s family and/or natural supports. The Family Clinician provides coaching and support while engaging the individual, their family, and/or natural supports in the NAVIGATE Family Education Programming.
* **Supported Employment and Education (SEE):** SEE Specialists help the individual meet their employment or educational goals. This may include assisting the individual in obtaining educational supports, referring the individual for career assessments, resume building, helping with the job application process, teaching interviewing skills, and providing skills or tips for how to stay in school or maintain employment.
* **Peer Specialists:** Peer Specialists are individuals with lived experience as recipients of mental health services. They serve as mentors to individuals served by The Discovery Team.

**Our Approach:**

The Discovery Team utilizes NAVIGATE, an evidence-based treatment model, as a primary modality to support individuals who have experienced an early episode of psychosis. NAVIGATE also provides education and support to families and/or natural supports. We provide individual therapy, family education, educational and vocational services, Peer Services, Case Management, and Community Engagement.

Treatment is geared to each individual and family’s unique needs, using a individual-centered, trauma-informed, and strengths-based approach. The Discovery Team’s core services include individual therapy, medication management, and family education. Peer and SEE Specialists are additional resources for any interested individual. Once accepted to the program, an intake is scheduled with the individual seeking services, their family and/or natural supports. If family and/or natural supports are involved, please provide contact information so that they can be included in services:

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| Name/Relationship: Click here to enter text. | Phone: Phone | Email: Email. |
| Name/Relationship: Click here to enter text. | Phone: Phone | Email: Email. |
| Name/Relationship: Click here to enter text. | Phone: Phone | Email: Email. |

May The Discovery Team contact the above people listed during the referral process: [ ]  Yes [ ]  No

* If permission is given, the individual being referred should initial and date:

Initial: initial. Date: pick a date.

Have referrals or inquiries been placed with any other early psychosis programs? [ ]  Yes [ ]  No

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| **Insurance Information** |

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| Primary Insurance: Click here to enter text. | ID Number: Click here to enter text. |
| Secondary Insurance: Click here to enter text. | ID Number: Click here to enter text. |

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| **Guardian Information (if applicable)** |

Does individual have a guardian(s): [ ]  Yes [ ]  No (if yes, please complete the following)

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| Name/Relationship: Click here to enter text. | Name/Relationship: Click here to enter text. |
| Address: Click here to enter text. | Address: Click here to enter text. |
| City: City State: State Zip Code: Zip Code | City: City State: State Zip Code: Zip Code |
| Email: Click here to enter text. | Email: Click here to enter text. |
| Phone: Click here to enter text. | Phone: Click here to enter text. |
| Primary Language: Click here to enter text. | Primary Language: Click here to enter text. |

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| **Behavioral Health History** |

Behavioral Health Diagnoses: Click here to enter text.

**Most Recent Behavioral Health Providers**

Psychiatry: [ ]  Yes [ ]  No **Names/Agency:**  Enter Names/Agency. Dates of Service: Enter date.

Therapy: [ ]  Yes [ ]  No **Names/Agency:**  Enter Names/Agency. Dates of Service: Enter date.

Other (Please describe): Click here to enter text.

If the individual has current outpatient providers, is the individual prepared to transfer care to a therapist and prescriber on The Discovery Team? [ ]  Yes [ ]  No

Do current providers know that a referral is being placed to The Discovery Team? [ ]  Yes [ ]  No

**Recent Hospitalizations**

Hospital/Dates of Admission and Discharge: Click here to enter text.

Hospital/Dates of Admission and Discharge: Click here to enter text.

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| **Medical History** |

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| Primary Care Physician (PCP): PCP | Phone: Click here to enter text. |
| PCP Address: Click here to enter text. | Allergies: Click here to enter text. |
| City: City State: State Zip Code: Zip Code | Medical Diagnoses: Click here to enter text. |

Current Medications and Dosages: Click here to enter text.

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| **Additional Information** |

Reason you feel this referral would be beneficial: Click here to enter text.

Is there anything else that would be helpful for us to know (preferences, etc.): Click here to enter text.

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| **Please list all possible availability for appointments:** |

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| --- | --- | --- | --- | --- | --- |
|  | Monday | Tuesday | Wednesday | Thursday | Friday |
| Morning | Enter time | Enter Time | Enter Time | Enter Time | Enter Time |
| Afternoon | Enter time | Enter time | Enter time | Enter time | Enter time |
| Early Evening | Enter time | Enter time | Enter time | Enter time | Enter time |

Please fax this form along with any clinical documentation, including Assessments, Admission/Discharge Summaries, and latest prescriber records to 781-482-7947, Attention: Tali Rojem or mail to The Edinburg Center/Attention: Tali Rojem, 205 Burlington Road, Bedford MA 01730. Referrals may also be sent to [discovery@edinburgcenter.org](file:///E%3A%5Cmy%5Cchi_Van%5Cworking%5Cdiscovery%40edinburgcenter.org).

If you have any questions please email [discovery@edinburgcenter.org](file:///E%3A%5Cmy%5Cchi_Van%5Cworking%5Cdiscovery%40edinburgcenter.org) or call Tali Rojem at 781-382-8349