



INSIGHT TEAM REFERRAL

GUIDANCE NOTES

1. This form is designed to help you decide whether the person being referred is eligible for an initial assessment interview by the Insight Service. It is NOT designed to help you make a diagnosis of psychosis.

2. The current agreed eligibility criteria are:

- One or more symptoms ticked in box A

OR

- Five or more symptoms ticked in box B

If the person being referred meets either of these criteria, and the criteria as detailed in the Insight leaflet, then an initial assessment interview should be offered automatically.

Insight will discuss this referral at our weekly team meeting and will contact you or the referred person directly.

3. If you have any doubts about whether to refer or not, or any immediate risk concerns please do not hesitate to telephone somebody from the Insight Team for advice.

Date of referral:

Name of person being referred:

DOB:

Age:

Sex:

- Male
 Female

Address:

Telephone No:

B **ADDITIONAL SYMPTOMS** (* in the last 6 months)

Does the person have any of the symptoms below? If so please describe:

Lacking Emotion

Irritability/Anger

Anxiety

Appetite Changes

Behaviour Changes

Belief that thoughts have speeded up or slowed down*

Depression

Deterioration in work or study*

Difficulties with memory or concentration

Disordered Language

Loss of energy or motivation*

Mood Swings

Perception that things around them have changed*

Sleep disturbances

Suspiciousness

Social withdrawal

C TRAIT/STATE RISK FACTORS OF PSYCHOSIS:

Does the person have any history, or family history of:

Mental illness

Abuse

Drug using

Accommodation problems

Financial difficulties

Criminal offending

Physical health problems

Environmental issues

D Other agencies already involved:

Is the person already known to Mental Health Services? If so, whom?

E Any risk concerns, e.g. suicide, violence, vulnerability?

F Any other issues: