UC Davis EDAPT & SacEDAPT Phone Interview Request Form

2230 Stockton Blvd, Sacramento CA, 95817

Fax: (916) 734-7539, Phone: (916) 734-7251

NOTE: This fax is requesting a phone interview with SacEDAPT. It is not a referral. The referring party must speak with SacEDAPT Staff before this fax is consider "received." Do not discontinue any current services until informed to do so by SacEDAPT staff**

Site Name: ____________________________ **Individual Providing Request:** ____________________________________

Phone: (____)______-_________ **Fax:** (____)______-_________ **Date & Time:** ____/____/_____ ____:_____ **AM/PM**

Referring Clinician E-mail: __________________________ **Date First Seen for Your Services:** ______/______/_________

1. **Provide information relevant for Medical Necessity for SacEDAPT/EDAPT Early Intervention Model. For an individual who may need higher level of care, please offer those services OR maintain current linkage to allow SacEDAPT/EDAPT time to evaluate referral and/or conduct eligibility assessment for EP services:**

Basic eligibility (please check all that apply)
☐ Client may be at high risk for developing psychosis ☐ Recent onset of psychosis (within past 2 years)
☐ Age 12-40 ☐ If Medi-Cal/Uninsured: Resides in Sacramento County

If the individual is requesting or in need of the following services, they may need a higher level of care than SacEDAPT can provide (please check all that apply):
☐ Current need for afterhours crisis support (e.g. current suicide ideation/behavior, self harm behavior)
☐ Needs urgent/emergency medication refill or support ☐ Urgent need for in-home or residential services
☐ History of psychotic episode over 2 years ago ☐ Known developmental disability or IQ<70
☐ Currently homeless OR has unstable/temporary housing ☐ Substance Use is current main treatment need

2. **Complete Screening survey found at** https://health.ucdavis.edu/psychiatry/specialties/edapt/index.html

☐ **Complete Referral Number:** ______________ ☐ Screener not able to be completed (reason:_______________)

3. **Please complete ALL CRITERIA THAT APPLY:**

☐ KTA/Special Population (Adoption, foster care, ward of the state, open CPS case, JJ/court involved):

____

☐ Current Mental Health Treatment Provider: *(Agency)*____

(Provider's Name) ___________________________ *(Provider's Phone Number)* (______) ________-_____________

☐ Recent ER Visit/Hospitalization: *(Date)* ______/______/_______ *(Location)* __________________________________

(Reason for Visit) ____

4. Did the client (& parent if a minor) **agree to a phone interview?**
☐ **No** *(STOP here and do not fax referral form)* ☐ **Yes** *(continue below)*

Client Name: ______________________________ **Client Contact: E-mail:** _____________________________________

Client DOB *(MM/DD/YYYY)*: ____/_____/______ **Home #**:(______) ___________-______________

Family Language: _________________________ **Cell #**:(______) ___________-______________

Client Insurance: ☐ Commercial/Private ☐ Uninsured ☐ Unknown ☐ Medi-Cal, in County: _______________

Parent/Guardian (***Required if minor***): _________________________ Relationship to client: ______________________

Contact: Home #:(______) _____-________ Cell #:(______) _____-________ Email: _____________________________

Home Address: ______________________________ City, State: _____________ Zip Code: _____________

Describe Reason for Request: Why is this person on the psychosis spectrum? Provide details on any factors noted above. Please note current risks or reason for recent hospitalizations:

Please Note: EDAPT Staff will follow up with the referrer to discuss the request within 24-48 business hours. *V4 11/24/2021*