Richmond Fellowship Queensland

Referral Form
Early Psychosis Psychosocial Service (EPPS)

Please complete and email with attachments to: eppsmetronorth@rfq.com.au

Client Details					
Client Name		**Date of Birth**			
Contact Number		**Country of Birth**			
Email Address		**Ethnicity**			
Street Address					
Gender Identity		**LGBTIQA+**			
Diagnosis - Primary		**Diagnosis - Secondary**			
Indigenous Identity		**Cultural & Linguistic Diversity**		**Interpreter Required**	
Primary Language		**NDIS Status**			
Accommodation Status		**Mental Health Act status**			
Referring Details					
Date of Referral		**Contact Number**			
Referrers Email		**Clinical Team**			
Referrer Name & Position					
Alternative Contact/ Alternative Decision Maker/Carer					
Name		**Relationship to client**			
Contact Number		**Contact Consent**			
Additional Information					
Reason for Referral – (e.g. any specific goals or support needs)					
Other Information – (e.g. urgent follow up required, discharge plans, other agencies providing support)					

Please indicate actions and attachments

Verbal consent recorded in IEMR/CIMHA	☐	**Risk Assessment / VRAM attached**	☐
Safety and/or Care Plan attached	☐	**Recovery Plan attached**	☐