25 YEARS 1998-2023
EST. 1998
RHS
Mental Health Solutions
208-523-5319

1675 Curlew Dr.
Ammon, ID 83406

Early Serious Mental Illness (ESMI)
Strength Through Active Recovery (STAR)
Referral Form

Agency Info

- Referring Provider: _____
- Agency: _____
- Contact Number and/or Email: _____
- Is the potential participant aware and in agreement with this referral? ☐ Yes ☐ No
- ROI in place? ☐ Yes ☐ No

Participant Info

- Name: _____
- Age: _____
- Diagnosis: _____
- The EMSI program is a specific program for individuals experiencing their first episode of psychosis or have had their first episode within the last 2 years. Please describe the first episode of psychosis (delusions, hallucinations, catatonia, paranoia, change in thinking patterns), the time frame in which it occurred (onset and course of qualifying symptoms), and if there have been any hospitalizations:

_____

_____

_____

_____

- Please indicate whether the potential participant has cognitive deficits such as intellectual or developmental disabilities:

_____

_____

- Please provide a brief psychiatric history, including relevant family/medical history:

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