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| --- | --- | --- | --- | --- |
| ***Wellness and Recovery After Psychosis (WRAP) Program Referral*** | | | | |
| Referring Clinician Name: |  | Clinician Phone: | |  |
| Patient Name: |  | Patient DOB: | |  |
| Patient Email: |  | Patient Address: | |  |
| Contact Phone Number:  *\*Please be sure this is up to date for scheduling* | |  | | |
| **Diagnoses** | | | | |
| Psychiatric Diagnoses: | |  | | |
| Comorbid Medical Diagnoses: | |  | | |
| Substance Use Disorder(s) (y/n):  *\*If yes, please Specify:* | |  | | |
| **Current Medications** | | | | |
| Medication | | Dose (For LAIs include last admin date and frequency) | | |
|  | |  | | |
|  | |  | | |
|  | |  | | |
| **Psychiatric History** | | | | |
| History of psychiatric hospitalization (y/n):  *\*If yes, include approximate dates and where hospitalized* | |  | | |
| History of suicide attempts (y/n):  *\*If yes, include when* | |  | | |
| Please attach additional clinical information describing the patient’s recent symptoms, presentation, and indications for specialty psychosis care. A recent evaluation note, hospital discharge summary, or original clinical summary will work. **Referrals are not considered complete without clinical information and will not be reviewed until that is received. Thank you for understanding.** | | | | |
| **Please select reason(s) for referral (select all that apply):** | | | | |
| First episode care (Pt is within first 5 years of onset of illness) | | | |  |
| Consultation only (e.g. diagnostic clarification, medication recommendations) | | | |  |
| Medication management | | | |  |
| Clozapine Clinic | | | |  |
| Injection Clinic | | | |  |
| Individual Psychotherapy | | | |  |
| Group Therapy | | | |  |
| Family Support/Psychoeducation | | | |  |
| Peer Support (Meeting with a certified peer specialist, a person with lived mental health experience) | | | |  |
| Employment/Education Support | | | |  |
|  | | | | |
| **Supports Outside of WRAP the patient is connected with** | | | | |
| Does the patient currently have an outpatient psychiatrist outside of WRAP?  If yes, are they interested in transferring care to WRAP providers? | | |  | |
| Is the patient connected with DMH, DDS, or any other supports? If yes please indicate specifically which services.  For example: Case management, ACCS Team, PACT Team, Group housing with staff supports, etc. | | |  | |

Steps to Scheduling an Evaluation/Intake Appointment

1. Confirm patient has been registered at Boston Medical Center
   * Call (617)-414-6060 to register if the patient is **NEW** to BMC
   * Make a PCP appointment upon registration
2. Send medical records. If the patient has been hospitalized within the past month, we will need the most recent discharge summary. Securely email that information along with the referral form to the contact below:
   * Email: [WRAP@bmc.org](mailto:WRAP@bmc.org)
   * Fax: (781)-559-0894
3. Once referral has been reviewed and approved, Ellie Reagan (Clinic Coordinator) will call the patient directly to schedule in the WRAP clinic.

**Please allow 10 business days for the referral to be reviewed. We receive many referrals and will do our best to respond to all referrals in a timely manner. If appropriate, we can typically schedule patients within 2 weeks for an intake. Unfortunately, that is not presently the case for patients under 18; Our child psychiatrist is booking out for up to two months and you will need to have a plan for bridging care.**

Questions/Concerns:

Always call **911** in case of a medical emergency or immediate safety concern.

Call the **BEST** Team for 24 Hour Psychiatric Crisis (800)-981-HELP (4357)

Call Ellie Reagan for questions about WRAP Clinic including but not limited to:

* Rescheduling an appointment
* Directions to our offices
* Hearing more about any of the services we provide
* Other questions about the clinic

Phone: 339-987-6050