Wellness and Recovery After Psychosis (WRAP) Program Referral

Referring Clinician					
Name:		***Referring Institution***: *(Hospital or Program)*		***Phone:***	
				Email:	

Patient Contact			
Patient Name:		*Patient DOB:*	
Patient Email:		*Best Phone Number for Scheduling:*	
Patient Address:			

Patient Diagnoses	
Psychiatric Diagnoses:	
Co-morbid Medical Diagnoses:	
Substance Use Disorder(s): **Consider and include cannabis use even if not formally diagnosed*	**Yes:** ☐ **No:** ☐
	**If YES, specify:*

Current Medications	
Medication	***Dose (For LAIs include last admin date and frequency)***

Psychiatric History	
History of psychiatric hospitalization:	**Yes**: ☐ **No**: ☐
	**If YES, include approximate dates and where hospitalized:*
	**If YES and currently hospitalized, include expected discharge date:*
History of suicide attempts:	**Yes:** ☐ **No:** ☐
	**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.	**Yes, clinical information has been sent and/or is included with this form** ☐

Why are you referring to WRAP?

Check **ONLY** one of the options below		
1. First episode psychosis (FEP) care for a primary psychotic disorder (patient is within first 5 years of onset of illness) ☐	**2. Multi-episode** outside of first 5 years of onset of illness and would benefit from specialized treatment (e.g. LAI, clozapine) to address psychotic symptoms ☐	**3. A one-time consultation visit** for the patient (e.g. diagnostic clarification, medication recommendations) ☐

If you checked ***EITHER*** FEP or multi-episode care (options #1 or #2), please select applicable services below:	
1. Ongoing medication management	**Yes**: ☐ **No:** ☐
2. Clozapine Clinic	**Yes:** ☐ **No:** ☐
	If yes, specify dose:
	Last labs:
	Monitoring frequency: Weekly ☐ Biweekly ☐ Monthly ☐
3. Long-acting Antipsychotic (LAI) Clinic	**Yes:** ☐ **No:** ☐
	If YES, specify LAI name:
	LAI dose and frequency:
	Last admin date and dose:
4. Individual Psychotherapy	**Yes:** ☐ **No:** ☐
5. Group Therapy (only for FEP Care)	**Yes:** ☐ **No:** ☐
6. Family Support/Psychoeducation (only for FEP Care)	**Yes:** ☐ **No:** ☐
7. Peer Support: Meeting with a certified peer specialist (mental health professional with lived experience)	**Yes:** ☐ **No:** ☐
8. Diagnostic or Neuropsychological testing	**Yes:** ☐ **No:** ☐
	if YES, specify referral question:

Supports Outside of WRAP	
Does the patient currently have an outpatient psychiatrist outside of WRAP?	**Yes:** ☐ **No:** ☐ *If YES, who:*
	If YES, are they interested in transferring care to WRAP providers? Yes: ☐ No: ☐
Is the patient connected with DMH, DDS, DCF, or any other supports? *For example: Case management, ACCS Team, PACT Team, Group housing with staff supports, etc.*	**Yes:** ☐ **No:** ☐
	If YES, please indicate specifically which services.
Are there pending referrals for this patient with other programs, specifically any early psychosis programs?	**Yes:** ☐ **No:** ☐
	If YES, what is the status of those referrals?

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 or fax that information along with the referral form to the contact below:
    - Email: 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 3 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