Valley|Cities
Behavioral Health Care

New Journeys Referral

New Journeys is a comprehensive evidence-based treatment approach for individuals who are experiencing first episode psychosis. This form is a request that an individual be screened for New Journeys and is not a guarantee of acceptance. You may make a referral by filling out this form and faxing it to the New Journeys Manager (253-661-8631) or by calling our referral line (206-408-5329) and leaving a message. After making a referral, you will be contacted within 2-3 business days. If the individual you are referring is in immediate danger to self or others or otherwise in crisis, please contact the King County Crisis Clinic, the 24 hour crisis line at 988, the nearest ED for assistance or call 911.

Contact info for referring person:	
Referred by Name/Agency:	Date:
Phone:	Fax:

Name of Referred Individual:	DOB:
Current Address:	Phone:
Name and phone number of legal guardian (if applicable):	
What is the individual's medical insurance?	

Does the individual/family speak a language in the home other than English?	☐ Yes	☐ No
If so, what language?		
Does the individual have an IQ below 70, developmental delays or an autism spectrum disorder?	☐ Yes	☐ No
Has the individual been diagnosed with schizophrenia, schizoaffective, schizophreniform, delusional disorder, brief psychotic disorder or unspecified psychotic disorder?	☐ Yes	☐ No
Does the individual have any medical conditions they are being treated for?	☐ Yes	☐ No
If so, what are the conditions?		

What symptoms has the referred person experienced or been observed experiencing:

☐ Speech that doesn't make sense, difficulty creating sentences or communicating a point
☐ Behaviors, speech or beliefs that are uncharacteristic for the individual
☐ Hearing voices or sounds that others do not hear
☐ Seeing things that others do not see
☐ Belief that others have put thoughts in their head or are taking thoughts out of their heads
☐ Belief that others can read their mind, they can read minds or they hear their thoughts out loud
☐ A significant decline in school, occupational, social functioning and/or personal hygiene
☐ A significant decrease or increase in appetite or sleep (e.g. sleeping too much or too little)

List examples of any other symptoms not noted above:

On what date did the symptoms start?

What, if any, safety concerns should we be aware of if we meet with the individual in person?

Are the above symptoms only present when the individual is experiencing severe depression or high levels of energy (e.g. mania)?	☐ Yes	☐ No
Are the above symptoms only present when the individual is intoxicated, under the influence of or withdrawing from drugs/alcohol (including marijuana)?	☐ Yes	☐ No
Is the individual aware you are making this referral *and* willing to be contacted by us?	☐ Yes	☐ No