UNC
SCHOOL OF MEDICINE

UNC OASIS Wake Program
Department of Psychiatry
410 Glenwood Ave, Ste 202
Raleigh, NC 27603
(919) 445-0401 main
(919) 445-0835 fax

Date of referral: _____

Internal Referral

Please provide us with some basic information to begin the referral process. Once received, our referral specialist will be in contact with you within 72 business hours to conduct an in-depth pre-screening via telephone to determine the client's appropriateness for our program. This form can be faxed to UNC OASIS Wake at (919) 445-0835, attention: "Referrals."

Inclusion Criteria

- Individuals between ages 15-30 at assessment
- First episode of psychosis was within the last 3 years
- No previous diagnosis of Pervasive Developmental Disorder (i.e. Autism Spectrum Disorder)
- No previous diagnosis of Intellectual Developmental Disability (i.e. assessment IQ of lower than 70)
- Substance Use Disorder is not primary diagnosis
- Psychosis was not solely substance-induced

Name: _____ Date of Birth: _____

Address: _____

County of residence: _____ Phone: (home/cell) _____

Family Contact: _____ Relationship: _____

Phone: (home/cell) _____ (work) _____

Reason for Referral: _____

_____

_____

First Onset of Psychosis: _____

Insurance: _____

Referral Source Information

Clinic/Facility Name: _____ Phone: _____

Patient's Provider Name(s): _____

Address: _____

Fax: _____ E-mail: _____

Form Completed By: _____ Date: _____

For OASIS Use Only: Date Received: _____