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: _____

Self or Family Referral

We understand that this is likely a stressful time for you or for your loved one. Please provide us with some basic contact information and our referral specialist will be in contact with you within 72 business hours to conduct an in-depth pre-screening via telephone to determine your appropriateness for our program. This form can be faxed to UNC OASIS Wake at (919) 445-0835, attention: "Referrals."

Name: _____ Date of Birth: _____

Address: _____

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

Insurance: _____

Family Contact: _____ Relationship: _____

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

Reason for Referral: _____

_____

_____

_____

_____

First Onset of Psychosis: _____

Form Completed By: _____ Date: _____

For OASIS Use Only: Date Received: _____