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 Wake Encompass 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
- Must live in Wake, Johnston, Cumberland or Durham County

Name: _____________________________________ MRN#: _________________________

County of residence: ____________________ Phone: (home/cell) _________________________

Family Contact: __________________________ Relationship: _________________________

Phone: (home/cell) ______________________ (work) ________________________________

Reason for Referral: ___________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

First Onset of Psychosis: ________________________________

Referral Source Information

Clinic/Facility Name: ______________________ Form Completed By: ________________________

Phone: ___________________________ Date: __________________