UNC STEP Community Clinic – Wake
New Patient Referral/Application Form

The UNC STEP Clinic is a specialty Clinic serving Wake County adult residents diagnosed with Schizophrenia, Schizoaffective Disorder and Bipolar Disorders only.

Patient's Name: _____ DOB: _____ Age: _____

Address: _____
Street Address City/State Zip code

County of Residence: _____ (only Wake Cty Residents accepted)
Is the address listed above and Group Home/Assisted Living, etc.? YES NO
If yes, provide best contact information for the facility: _____

Patient PH number(s): Mobile #_____ Home/other: #_____
Other person number: #_____ Person/Relationship: _____

Does the patient have a LEGAL guardian? YES NO
Legal guardians, whether related or not must have been appointed by the court.
If yes, the STEP Clinic requires the submission of the
"Letters of Guardianship" Documents.
Legal Guardian Name & Ph#: _____ Ph#: _____

Family/Other Contact: _____ Ph#: _____
Name & relationship

Patient's Behavioral Health Diagnosis: _____

Current/Most recent Behavioral Health Provider: _____

_____
Contact information: Phone number, Fax number Address if known.

The STEP Clinic requires patient's records from Current/Most Recent Behavioral Health providers before acceptance to the program.
Patients are responsible for requesting those records.
Please ask providers to fax records to the STEP Clinic at (919) 445-0405.

# of past hospitalizations: ____ When was your last hospitalization? _____
Location of your most recent hospitalization: _____
Name and address of hospital

Please complete **both** sides as completely as possible and return to: UNC STEP Clinic, 401 East Whitaker Mill Road, Raleigh, NC 27608 or fax 919-445-0405

Insurance: Do you currently have:
Medicaid? YES NO, if yes: Medicaid ID#:_____
Medicare/Medicare advantage plan? YES NO
If yes: Type & ID#:_____
Do you currently other have insurance? YES NO
If yes: Insurance Name & ID#:_____

What is your employment status? (Please circle answer)
Employed-fulltime Employed-part time Unemployed Retired Disabled

If employed, please provide employer name: _____
If retired, retirement date: _____

Marital Status: _____
If married, is your spouse: (please circle answer)
Employed-fulltime Employed-part time Unemployed Retired Disabled

If spouse employed, please provide employer name: _____
If retired, retirement date: _____

What is your: Gender: _____ Race: _____
(Please note if you choose not to answer)

Preferred Language: _____ Do you need an interpreter? YES NO
UNC STEP Clinic will do our best to accommodate requests for interpreters. Some interpreters may be virtual.

What are your current Medications & Dosage

_____ _____
_____ _____
_____ _____

Current/past Drug/Alcohol use? YES NO (Describe)_____
Current/past legal problems? YES NO (Describe)_____
History of Intellectual/Developmental Disabilities? (Describe) _____

_____
Current Primary Care Provider

_____
Physician Name, Clinic Name, Address, Phone & Fax number

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