



# UNC

## SCHOOL OF MEDICINE

UNC Wake Encompass  
Department of Psychiatry  
401 E. Whitaker Mill Rd  
Raleigh, NC 27608  
(919) 445-0401 main  
(919) 445-0835 fax

Date of referral: \_\_\_\_\_

### Inpatient Hospital Provider Referral

Please closely review the following inclusion criteria prior to submitting this form to our referral specialist. Once the form has been completed in full, please fax this and all records to UNC Wake Encompass at (919) 445-0835, to the attention of "Referrals." If you need a Release of Medical Information form, please visit:

<http://www.uncmedicalcenter.org/app/files/public/1259/pdf-MedCtr-Release-of-Medical-Information-English.pdf>,

and request that the records be sent to UNC OASIS Wake via fax at (919) 445-0835.

#### 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, Durham, and Harnett counties

#### Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

County of residence: \_\_\_\_\_ Phone: (home/cell) \_\_\_\_\_

Family Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: (home/cell) \_\_\_\_\_ (work) \_\_\_\_\_

Insurance: \_\_\_\_\_

#### Referral Source Information

Clinic/Facility Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient's Provider Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Mental Health History**

Date of onset of psychotic symptoms: \_\_\_\_\_

Date of first contact with current provider: \_\_\_\_\_

Current Treatments for Psychosis: (Check all that apply)

Medication Management

Psychotherapy

Past Treatments for Psychosis: (Check all that apply)

Medication Management

Psychotherapy

Current Psychotic Symptoms: (Check all that apply)

Delusions

Hallucinations

Disorganized Thinking/Speech

Disorganized Behavior

Current Substance Use: \_\_\_\_\_

Current Suicidality: \_\_\_\_\_

Current Aggression/Violence: \_\_\_\_\_

Current Prescribed Medications: \_\_\_\_\_

Current Legal Involvement: \_\_\_\_\_

Is the patient current under an Outpatient Commitment Order? \_\_\_\_\_

**Past Hospitalizations:**

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_

Reason for Admission: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_

Reason for Admission: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_

Reason for Admission: \_\_\_\_\_

Form Completed By: \_\_\_\_\_ Date Completed: \_\_\_\_\_

**Previous outpatient providers:**

Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_

Reason for Treatment: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_

Reason for Treatment: \_\_\_\_\_

Form Completed By: \_\_\_\_\_ Date Completed: \_\_\_\_\_

**For Wake Encompass Use Only:** Date Received: \_\_\_\_\_