School of Medicine

**Name of Patient**_____
**Date of Birth**_____

# OASIS Clinic Referral Form

Department of Psychiatry

Fax Referrals: (984) 974-9646
*(Please mark each page with name/date of birth of patient)*

The OASIS Clinic is a First Episode Psychosis (FEP) clinic. Please take a moment to review the following information before submitting a referral. In order to process the referral, we will need a complete set of records. If you have questions about a referral, call the Clinical Director, Emily Parsons, at 919-962-1350.

## Eligibility Guidelines

-Individuals between ages 15-30
-Onset of psychosis within the last 3 years
-Individuals with mild intellectual disability and/or level 1 Autism may be appropriate for admission pending review.

**Type of Referral**
Inpatient Hospital
Outpatient Provider
Self/Family Referral

**Patient Information**
Name
Date of Birth
Phone Number
Address (Include City)

**Family Contact**
Name
Relationship
Phone Number
Email

**Insurance**
Insurance Name
Insurance Number

**Referral Source Information**
Clinic/Facility
Contact Name
Phone Number
Email

**Name of Patient**_____
**Date of Birth**_____

**Mental Health History**

Date of onset of psychotic symptoms

Diagnosis (if applicable)

Description of symptoms

**Hospitalizations**

| Dates | Name of Hospital | Reason for Hospitalization |
|---|---|---|
| | | |
| Dates | Name of Hospital | Reason for Hospitalization |
| | | |
| Dates | Name of Hospital | Reason for Hospitalization |
| | | |

**Additional Information**

Notes (optional)

**Form completed by:**

Date completed

Title/Role