UNC SCHOOL OF MEDICINE

THE OASIS PROGRAM
DEPARTMENT OF PSYCHIATRY

Phone: (919) 962-1401
Fax: (919) 962-7373

Outpatient Community 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 the OASIS program at 919-962-7373, to the attention of "Referrals". If you need a Release of Medical Information form, please see the Referral page on our website, and request that the records be sent to the OASIS Program via fax to 919-962-7373.

Inclusion Criteria

- Individuals between ages 15-36
- First episode of psychosis was within the last 3 years
- No previous diagnosis of Pervasive Developmental Disorder (i.e. Autism Spectrum Disorder) or Intellectual Developmental Disability (i.e. Mental Retardation)
- Substance Use Disorder is not primary diagnosis
- Psychosis was not solely substance-induced

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: _____

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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: _____

For OASIS Use Only: Date Received: _____

Referral Taken By: _____ Date Contacted: _____

Accepted: _____ Referred Out: _____ Initial Appointment: _____