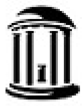

THE OASIS PROGRAM
DEPARTMENT OF PSYCHIATRY

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

Inpatient Hospital Providers 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: ____

***

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: ____

Form Completed By: _______________________________ Date Completed: ___________________

For OASIS Use Only: Date Received: ___________________

Referral Taken By: _____________________ Date Contacted: ___________________

Accepted: ______________ Referred Out: ______________ Initial Appointment: ______________