THE OASIS PROGRAM
DEPARTMENT OF PSYCHIATRY

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

Internal Referral

Please provide us with some basic information to begin the referral process. Once received, our referral specialist will be in contact with you within 72 business hours to conduct an in-depth pre-screening via telephone to determine the client's appropriateness for our program. This form can be faxed to the OASIS program at 919-962-7373, to the attention of "Referrals".

Name: ______________________________________ Date of Birth: __________________________

Address: ____

County of residence: ___________________ Phone: (home/cell) _______________________________

Family Contact: _________________________________ Relationship: ___________________________

Phone: (home/cell) ______________________________ (work) ________________________________

Reason for Referral: ____

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First Onset of Psychosis: ____

Insurance: ____

Referral Source Information

Clinic/Facility Name: ____________________________________ Phone: ________________________

Patient's Provider Name(s): ____

Address: ____

Fax: ______________________________ E-mail: ____________________________________

Form Completed By: __________________________________ Date Completed: __________________

For OASIS Use Only: Date Received: ___________________

Referral Taken By: _____________________ Date Contacted: __________________

Accepted: ______________ Referred Out: ______________ Initial Appointment: ______________