UNC SCHOOL OF MEDICINE

THE OASIS PROGRAM
DEPARTMENT OF PSYCHIATRY

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

Self or Family Referral

We understand that this is likely a stressful time for you or for your loved one. Please provide us with some basic contact information and our referral specialist will be in contact with you within 72 business hours to conduct an in-depth pre-screening via telephone to determine your 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: _____

_____

_____

First Onset of Psychosis: _____

Insurance: _____

Form Completed By: _____ Date Completed: _____

For OASIS Use Only: Date Received: _____

Referral Taken By: _____ Date Contacted: _____

Accepted: _____ Referred Out: _____ Initial Appointment: _____