WeCARE2 Program
621 Micaville Loop, Suite, 600
Burnsville, NC 28714
Main Number: (828) 675-4116

Date of referral: _____

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 Mountain Community Health Partnership at (833) 947-3905, to the attention of "Referrals". Release of Information consent forms can be sent to MCHP WeCARE2 via fax at (833) 947-3905 to the attention of "WeCare2".

Inclusion Criteria

- Individuals between ages 15-30 at assessment
- First episode of psychosis was within the last 3 years
- No previous diagnosis of Pervasive Developmental Disorder (i.e. Autism Spectrum Disorder)
- No previous diagnosis of Intellectual Developmental Disability (i.e. assessment IQ of lower than 70)
- Substance Use Disorder is not primary diagnosis
- Psychosis was not solely substance-induced
- Must live in Yancey, Mitchell, Avery, or Burke County

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 currently 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: _____

Facility Name: _____

Address: _____

Phone: _____ Fax: _____

Date of Admission: _____ Date of Discharge: _____

Reason for Admission: _____

Form Completed By: _____ Date Completed: _____

Previous outpatient providers:

Provider Name: _____

Address: _____

Phone: _____ Fax: _____

Date of Admission: _____ Date of Discharge: _____

Reason for Treatment: _____

Provider Name: _____

Address: _____

Phone: _____ Fax: _____

Date of Admission: _____ Date of Discharge: _____

Reason for Treatment: _____

Form Completed By: _____ Date Completed: _____

For MCHP Administrative USE: Date Received: _____