**View Point Health
Community Services Referral**





###

###  Date of Referral:

### Individual’s Name:       DOB:       Age:     SSN:

Is individual currently receiving care from VPH? Y [ ]  N [ ]  (If Y, please include CID#     )

Primary Language (Hispanic or other)       Is Individual aware of your referral? Y [ ]  N [ ]

Individual’s Home Address:       City:       County:       Zip:

Main Phone #:       Email (if applicable)       Is Individual currently homeless? Y [ ]  N [ ]

Is Individual currently on probation? Y [ ]  N [ ]  (If Y, please provide PO contact information with referral)

Does Individual have a legal guardian? Y [ ]  N [ ]  (If Y, please include legal guardian information with referral)

Emergency Contact Name       Emergency Contact Phone #       May VPH contact Emergency Contact? Y [ ]  N [ ]

**Where are you referring from? Please select one**

|  |  |  |
| --- | --- | --- |
|  [ ] Georgia Regional Hospital  [ ] County Jail  [ ] State Prison [ ] Public Defender’s Office |  [ ] DBHDD [ ] Court [ ] Probation Office [ ] Private Acute Hospital |  [ ] Crisis Stabilization Unit  [ ] Another Agency Referral [ ] Re-entry (County      )  [ ] Other:       |

Name of Person Referring:       Email:       Main Phone #:

**An Individual must have a verified diagnosis for severe and persistent mental illness. Please select diagnosis below:**

|  |  |  |  |
| --- | --- | --- | --- |
|  [ ] Schizophrenia [ ] Schizoaffective |  [ ] Depression [ ] Bipolar  |  [ ] Phobia [ ] Anxiety  | [ ] Other:      Has first episode of psychosis occurred within the last 24 months? Y [ ]  N [ ]  |

Substance Abuse Diagnosis (if applicable)       Is Individual’s SA diagnosis for at least 6 months? Y [ ]  N [ ]

Medical/Physical Challenges or Diagnoses (if applicable)       Current Medications (if applicable):

**Please select all applicable challenges below for the Individual referred:**

[ ]  Hygiene [ ]  Nutritional [ ]  Maintaining personal affairs [ ]  Housing [ ]  Ability to avoid danger/hazards

[ ]  Daily living skills [ ]  Sustainable employment [ ]  Safe living situation [ ]  Other

**Please select any of the following services the Individual has received in the past year:**

|  |
| --- |
|  [ ] Psychiatric Hospital (# of admissions      ) # of these admissions in the past 180 days        [ ] Crisis Stabilization Unit (# of admissions      ) # of these admissions in the past 180 days        [ ] Jail (# of incarcerations      ) # of these incarcerations in the past 180 days        |

**Please select any of the following services the Individual has received in the 180 days:**

|  |
| --- |
|  [ ] Community-Based Services (ineffective service) Please describe which service       [ ] In-clinic crisis stabilization [ ]  Other:       From previous services received, please include any safety concerns (if applicable)        |

**Please select any applicable benefits for the Individual**

|  |  |  |
| --- | --- | --- |
|  [ ] Medicaid (#     ) [ ] Medicare (#     ) |  [ ] SSI (Monthly amount:      ) [ ] Private Insurance |  [ ] Payee (Name of Payee:      ) [ ]  Other:       |

Please provide a brief description of presenting problems and current behaviors

**FINAL STEP - Please email referral form and all supporting documents to referrals@vphealth.org**

Thank you for the referral. If you do not hear from us within 48 hours, please contact Lori Cole at (lori.cole@vphealth.org).

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*VPH Centralized Access Use Only –*

[ ]  ACT [ ]  ICM [ ]  CSS [ ]  Project LIGHT [ ]  Horizon Respite [ ]  DNM (Referred to:      )