**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:      )