**View Point Health
STRIVE CLUBHOUSE**





###

###  **Date of Referral**:

### **Individual’s Name**:       **Middle Int**.       **DOB**:       **Age**:       **SSN**:

**Race:**       **Does individual have a legal guardian?** Y [ ]  N [ ]  (If Y, please include legal guardian information with referral)

**Parent/Guardian Name**:       **Parent/Guardian Phone Number**:

**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 [ ]

**Home Address**:       **City**:       **County**:       **Zip**:

**Home Phone #**:       **Email** (if applicable)

**Medicaid/Insurance Number**:

**Living Situation**: **Private Residence** [ ]  **Shelter** [ ]  **Correctional Facility** [ ]  **Foster Care** [ ]  **Group Home** [ ]  **Other** [ ]

**Caregiver Resources (Check ALL that apply)**: Inability to meet basic needs of youth [ ]  Potentially dangerous environment [ ]

Impairment in Caregiver judgment-functioning [ ]  Caregiver hostile/rejecting towards youth [ ]  Alleged/actual abuse in home [ ]

Domestic violence [ ]  Parental illegal activities [ ]

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

**Education**: School      Grade:       Phone:       Contact:

 EBD/Psychoeducation[ ]  Special Education[ ]  Alternative School[ ]  Currently: Suspended[ ]  Expelled[ ]

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

|  |  |  |
| --- | --- | --- |
|  [ ] DJJ Commited [ ]  DFACS  [ ]  Mental Health Court [ ]  Public Defender |  [ ] Post-secondary education [ ]  Public Schools [ ]  Juvenile Court [ ] Inpatient Hospital |  [ ] VPH Program  [ ] Family member [ ] DBHDD [ ] Other:       |

**Name of Person Referring**:       **Email**:        **Phone** #:

**Secondary Contact**:       **Email**:       **Phone** #:

**Presenting Circumstances: (Recent episode of behaviors/symptoms that require services at this time)**

|  |
| --- |
|       |

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

**FINAL STEPS**

* **Don’t forget to include all supporting documentation for your answers above**
* **Once completed, please email referral form and all supporting documents to STRIVE@vphealth.org**

We will review your referral and contact you to discuss next steps. If you have not heard back from us within two business days, please contact Strive Clubhouse at (678) 209-2446. Thank you for your referral.