**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)**

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| --- |
|  |

**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.