**View Point Health  
Autism 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

**What service are you referring to? Please select all that apply**

|  |  |
| --- | --- |
| **Diagnosis/Assessment**  **ABA Therapy**  **Occupational Therapy** | **Speech Therapy**  **Feeding and Swallowing Therapy**  **Family Education and Support** |

Name of Person Referring:       Email:       Phone #:

**Any previous/current mental health diagnosis? Please select from below:**

|  |  |  |  |
| --- | --- | --- | --- |
| Mood Disorder  ADHD  Autism Spectrum | Depression  Anxiety  Bipolar | Phobia  Schizophrenia  IDD | Other:  When was the most recent diagnosis? |

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:**

|  |  |
| --- | --- |
| Outpatient mental health services?  If yes where  IDD services? If yes where | Psychiatric Hospital? If yes how many  Homelessness? If yes # of episodes       Jail? If yes # of incarcerations |

**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 autism@vphealth.org**

Thank you for the referral. If you do not hear from us within 48 hours, please contact Pej Mahdavi at (pej.mahdavi@vphealth.org).